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NURSING CARE HOUR STANDARDS STUDY
HCSD Report #81-009
Part II thru Part IV

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Nursing Care Hour Standards Study: Part II
Critical Care Patient Classification Subsystem

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Final Report

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NURSING CARE HOUR STANDARDS STUDY: PART II CRITICAL CARE PATIENT CLASSIFICATION SUBSYSTEM

A. INTRODUCTION

Part II Critical Care Patient Classification Subsystem addresses the development and testing of a multidimensional factor-evaluation designed patient classification system for critical care. If nursing managers are to make sound administrative decisions on critical care staffing needs, they must measure the appropriate nursing care activities and use the best measuring tool available. The best tool would be an acceptable reference standard, namely, the number of hours of nursing care required to meet safe essential patient care needs with the proper mix by skill level of care providers. The present study has attempted to develop and provide such a tool for critical care. The approach undertaken also considered the fact that time accountability is the principle commodity in accounting for human resource utilization.

B. OBJECTIVES

The two objectives for Part II Critical Care Patient Classification Subsystem were:

1. To develop a factor-evaluation designed patient classification subsystem for critical care which would provide a better staffing mix based on quantified direct nursing care requirements.
2. To determine if the Critical Care Patient Classification Subsystem demonstrates validity and reliability.

C. CRITICAL CARE PATIENT CLASSIFICATION SUBSYSTEM

The format and factor-evaluation design of the patient classification subsystem for critical care was devised to enable professional nurses in its use to ascertain inpatient needs for direct nursing care. The Critical Care Patient Classification Subsystem was designed with five components: (1) patient classification instrument mathematical model; (2) patient classification instrument; (3) patient classification instrument instructional information; (4) patient classification tabulation form; and (5) methodology for determining care provider mix. The methodology for the development of each component will be discussed.

1. Critical Care Instrument Mathematical Model.

The critical care patient classification instrument mathematical model (Appendix A) was designed for either an automated or manual system. The design of the model delineates the direct nursing care activities, frequency rate for a 24-hour time frame, minimal essential mean tasking time, and the appropriate weighted score. The organization of the mathematical model displays all dimensions of direct patient care and all direct nursing care activities within each dimension labeled as patient care indicator. The critical care patient classification instrument mathematical model was designed with the following patient care indicators:

- a. Hygiene
- b. Nutrition/Elimination
- c. Mobility/Exercise/Safety
- d. Medication
- e. Vital Signs/Assessment/Diagnostic Tests
- f. Psychological/Patient Teaching
- g. Gastrointestinal
- h. Respiratory
- i. Cardiovascular/Temperature Regulation
- j. Skin
- k. Skeletal/Neurological/EENT
- l. Urological/Gynecological

The weighted score for each direct nursing care activity was determined by selecting the best common denominator to fit the total number of activities included within the critical care patient classification instrument mathematical model. The following weighted factor scale was established: three minutes equals one point; two to three minutes equals one point; and less than two minutes equals 0.5 point. This point conversion scale allows for simple arithmetic summing to quantitate the hours of direct nursing care required for critical care patients, and even if all of the direct nursing care activities were required for a critical care patient the error rate would not exceed plus or minus thirty minutes.

The critical care patient classification instrument mathematical model was designed for the quantification of direct nursing care requirements for adult medical intensive care, surgical intensive care, thoracic-cardiovascular intensive care, trauma intensive care, neurosurgery intensive care, and coronary intensive care.

2. Critical Care Patient Classification Instrument.

The critical care patient classification instrument (Appendix B) was designed for factor evaluation. Extensive comparative analyses were conducted for the determination of the patient care indicators which were considered to represent those nursing care activities that have the greatest impact on nursing care time. Based upon these findings thirteen patient care indicators were incorporated within the factor-evaluation designed instrument. Therefore, this type of design allows for the identification of direct nursing care activities for each patient care indicator.

The critical care patient classification instrument was designed to provide a simple tool in which the professional nurse needs only to rate those direct nursing care activities which are appropriate for the patient being rated. The direct nursing care activities scored on the instrument must have been performed by nursing personnel or assistance provided to other staff members performing the activity. If the patient performs self-care activities, then only those direct nursing care activities performed by nursing personnel are scored. The system was designed so that each patient needs only one rating for each 24-hour rating period. The ratings are completed at the end of the 24-hour rating period and are reflective of the preceding 24-hour time frame. The normal rating period was 0700 to 0700 hours; however, patients who were hospitalized less than 24 hours were also rated. In those patients who were within the system less than 24 hours, the ratings were reflective of the time period that the patient was present within the hospital system.

The instrument was designed to allow for the actual rating of each patient to be accomplished by selecting the frequency rate for each direct nursing care activity that was required during the rating period. Therefore, rating of the patient on the critical care patient classification instrument was accomplished by selecting the frequency rate from the options provided in the instrument. The instrument was designed so the frequency rate for each direct nursing care activity has a corresponding point value labeled as weighted score. The critical care patient classification instrument was designed to allow for collection of demographic information. The keypunch spaces one through twelve were provided for data collection which best meets the requirements of the medical treatment facility. The format for the critical care patient classification instrument follows the same format as the critical care patient classification instrument mathematical model. Therefore, the patient care indicators delineated on the critical care patient classification mathematical model comprise the format for the critical care patient classification instrument. As was presented earlier, the patient care indicators were identified as those groupings of direct nursing care activities which most influence the total patient care requirements. Based upon the design of the critical care patient classification instrument it is the total points within each patient care indicator that determines the patient care indicator score (PCIS). The sum of the patient care indicator scores determines the total points score and category of care for the rated patient.

The critical care patient classification instrument was developed with the following classification scheme as displayed in Table 1.

Table 1
Critical Care Patient Classification Scheme

Total Points	Hours of Care	Category of Care
40-79	2 thru 3	2
80-159	4 thru 7	3
160-239	8 thru 11	4
240-499	12 thru 24	5
500-720	25 thru 36 or more	6

A unique feature considered in the development of the instrument is the option of including infrequently occurring direct nursing care activities which impact significantly on nursing workload, and can be included in the rating under "other therapeutic activities/modalities."

3. Critical Care Patient Classification Instrument Instructional Information.

The critical care patient classification instrument instructional information component (Appendix C) was developed to provide adequate information for the user to consistently apply the same methodology for rating patients' direct care requirements. The organization of the operational definitions and weighted score for each direct nursing care activity follows the same format as the critical care patient classification instrument mathematical model and critical care patient classification instrument. To reduce the redundancy of the operational definitions provided, each direct nursing care activity also includes: (1) identify and screen the patient; (2) explain the procedure to the patient; (3) raise, lower, or adjust the bed before and after the nursing activity; and (4) clean and straighten area. The score provided for each direct nursing care activity is for a frequency of one.

In utilizing the critical care patient classification instrument instructional information component the score for each direct nursing care activity applies only to the Critical Care Patient Classification Subsystem for which it was designed. The critical care patient classification instrument instructional information component contains the listing of those infrequently occurring direct nursing care activities which impact significantly on nursing workload, and each of these direct nursing care activities are included in the rating under "other therapeutic activities/modalities." This list of direct nursing care activities is not all-inclusive, as the frequency with which some direct nursing care activities occurred was not sufficient to permit an accurate analysis or generation of a valid score. Moreover, in rating the patients' direct nursing care requirements, only those activities provided are to be utilized for rating the direct care requirements.

4. Critical Care Patient Classification Tabulation Form.

The critical care patient classification tabulation form (Appendix D) was designed for the recording of summary data. After the assessment of direct nursing care requirements has been completed by the professional nurse, the unit clerk can use the critical care patient classification tabulation form to record the patient care indicator scores for each patient. The instructions for recording of patient data are located within the critical care patient classification instructional information component. The data accumulated to this point will provide the necessary information for determining category of care and the hours of care within each patient care indicator for the clinical unit.

The results from extensive data analyses were utilized to design the critical care patient classification tabulation form. These analyses demonstrated that distribution of hours of care within each patient care indicator and not the category of care determines the mix by skill level of care providers required to meet the rated direct nursing care requirements for critical care inpatients. It must be emphasized that both category of care and hours of care within each patient care indicator can determine man-hour requirements, but only the hours of care within each patient care indicator can determine the best mix by skill level of care providers.

Since all medical treatment facilities do not have automated systems readily available, the critical care patient classification tabulation form was designed to allow for manual computations, as well as keypunching of the patient care indicator scores. Lastly, the critical care patient classification tabulation form was designed with the same format as the critical care patient classification instrument mathematical model, critical care patient classification instrument, and critical care patient classification instrument instructional information components.

5. Methodology for Determining Care Provider Mix for Critical Care.

The methodology for determining care provider mix for critical care (Appendix E) was developed for the purpose of providing the best mix by skill level of care providers. The diversity of direct nursing care activities requires a more complex mix of personnel, therefore, more sophisticated techniques are required to meet these demands. During the timing and observational studies the observers recorded the number and skill level of care providers for each direct nursing care activity. These data were utilized to establish personnel mix percentage scores for each direct nursing care activity. These personnel mix percentage scores were utilized in the development of the personnel percentage table for care provider for critical care patients. The percentage table for provider mix for critical care was developed by collapsing the personnel percentage scores for each direct nursing care activity within each patient care indicator. Table 2 displays the percentage table for care provider mix for critical care.

Table 2
Percentage Table for Care Provider Mix for Critical Care

	Professional	Technical	Paraprofessional
Hygiene	21	71	8
Nutrition/Elimination	36	58	6
Mobility/Exercise/Safety	34	60	6
Medication	88	12	0
Vital Signs/Assessment/ Diagnostic Tests	49	48	3
Psychological/Patient Teaching	65	35	0
Gastrointestinal	59	41	0
Respiratory	39	58	3
Cardiovascular/ Temperature Regulation	69	30	1
Skin	41	52	7
Skeletal/Neurological/EENT	32	55	13
Urological/Gynecological	27	66	7
Other Therapeutic Activities/Modalities	46	49	5

The mix by skill level of care providers can easily be determined by utilizing the summary data from the critical care patient classification tabulation form and the percentage table for care provider mix for critical care. This approach differs significantly from previous patient classification systems which match category of care with mix of personnel. Present findings demonstrate that the hours of care within each patient care indicator was the determinant for the mix by skill level of care providers and not the category of care. It must be noted that patient classification systems that match category of care with mix of personnel make the major assumption that all patients in the same category of care have the same direct nursing care requirements; hence, the same mix of personnel can meet those care requirements. However, the present findings do not support this assumption.

It is important to note that the percentage table for care provider mix for critical care was developed specifically for critical care clinical services and is not generalizable to other inpatient clinical services. Moreover, the percentage table for care provider mix for critical care applies only to the adult patient.

D. DATA COLLECTION AND DATA ANALYSIS

1. Validity Determination.

Validity studies were conducted to determine if the Critical Care Patient Classification Subsystem demonstrated content-related and criterion-related validity. Professional nursing judgment was involved in the original design of the critical care patient classification instrument and was again required for validation of the content of the instrument. It is of importance to note that during all data collection efforts, the participants had the option of and were encouraged to indicate inadequacies in the Critical Care Patient Classification Subsystem and suggest modifications.

Having completed the content-related validity testing, correlation coefficients were computed to determine the relationship of documented direct nursing care requirements with the critical care patient classification instrument.

Correlation coefficients for documented direct nursing care requirements with the critical care patient classification instrument mathematical model for two independent testings are displayed in Table 3.

Table 3

Validity: Correlation Coefficients for Documented
Direct nursing Care Requirements with
the Critical Care Patient Classification Instrument Mathematical Model

Critical Care	Correlation Coefficients	
	Test 1	Test 2
Direct Nursing Care Requirements Mathematical Model	.99	.99

Observational studies were conducted to determine the relationship of the critical care patient classification instrument to the actual observed and timed measurements of direct nursing care activities. The criterion-related validity coefficients for critical care are displayed in Table 4.

Timed measurements refer to the actual measurements by stopwatch; observed frequencies refer to actual observed frequency rates for each direct nursing care activity, and hours of care were established utilizing the appropriate minimal essential mean tasking time. Assessed requirements refer to the total hours of care established through consensus nursing judgment. As shown in Table 8 the criterion-related validity coefficients for critical care ranged from $r = .97$ to $r = .99$.

Table 4

Criterion-Related Validity Coefficients for Timed Measurements,
Observed Frequencies and Assessed Requirements

Hours of Direct Nursing Care	24-Hour Study Period			
	Mean	SD	95% CI	Pearson's r
Timed Measurements	4.50	3.79	2.21-6.78	.97
Observed Frequencies	5.40	5.90	1.83-8.96	
Timed Measurements	4.50	3.79	2.21-6.78	.98
Assessed Requirements	5.89	6.08	2.21-9.56	
Observed Frequencies	5.40	5.90	1.83-8.96	.99
Assessed Requirements	5.89	6.08	2.21-9.56	

2. Reliability Determination.

Reliability studies were conducted to determine: (a) if the critical care patient classification instrument demonstrated statistically significant interrater reliability for inpatient classification; and (b) if the individual patient care indicators displayed internal consistency.

Prior to initiation of the interrater reliability studies, the professional nurse raters received an orientation to and standardized instructions about the instrument used in the study. A two-hour orientation period was held for group presentation, followed by individual orientation by the project officer. The raters were given a minimum of ten days in which to practice rating patients using the Critical Care Patient Classification Subsystem.

A schedule of data collection for the critical care units were devised to allow for rating the patients on two preselected days per week. The study was conducted over an eight-week period with sixteen data collection days. The time span schedule, commencing in September 1980 and ending in January 1981, required four months to complete. The data collection periods were staggered to allow for the project officer to initiate the study within the four medical treatment facilities as follows: William Beaumont Army Medical Center; Eisenhower Army Medical Center; Darnall US Army Community Hospital, Fort Hood; and Worack US Army Community Hospital, Fort Bragg.

Sixteen data collection periods were conducted within the four medical treatment facilities. Ratings were completed on the entire patient population of all adult critical care units. Each of the 584 inpatients were rated by independent, trained pairs of professional nurse raters. In order to establish a level of quality control for the data collection efforts at the unit level, the forms were collected by a facility project officer. The facility project officer was responsible for checking the instruments for completeness, legibility, reconstruction of any missing data and pairing the match pairs of data from the two professional nurse raters. At the end of each week, the facility project officer mailed the completed instruments to HCSD using the preaddressed envelopes provided by HCSD. The HCSD staff edited each instrument and recomputed all scores to assure accuracy prior to coding of data for keypunching.

The patient population consisted of 371 males and 213 females with a mean age of 48 years. A description of the patient population data is presented in order to provide a framework for the analyses of the study results. Twenty-three pediatric patients were erroneously rated on the critical care patient classification instrument and these pediatric patients were included within the data presented. The category of care by age group for rater one vs rater two is shown in Table 5.

ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE					
Feeding (16.1591)	(1) 16.1591 5	(2) 32.3182 11	(3) 48.4773 16			
Serving Meal Tray, with Preparation (2.6073)	(1) 2.6073 1	(2) 5.2146 2	(3) 7.8219 3			
Special Feeding - Hyperalimentation, IV (6.0009)	(1) 6.0009 2	(2) 12.0018 4	(3) 18.0027 6	(4) 24.0036 8	(6) 36.0054 12	(8) 48.0072 16
Special Feeding - Nasogastric/Gastrostomy (3.7195)	(1) 3.7195 1	(2) 7.4390 2	(3) 11.1585 4	(4) 14.8780 5	(6) 22.3170 7	(8) 29.7560 10
Measuring & Recording Intake (.8583)	(3) 2.5749 1	(6) 5.1498 2	(9) 7.7247 3	(12) 10.2996 3	(18) 15.4494 5	(24) 20.5992 7
Measuring & Recording Output - Urine/Liquid Feces/Vomit/Diaper or Bed Linens (1.0877)	(3) 3.2631 1	(6) 6.5262 2	(9) 9.7893 3	(12) 13.0524 4	(24) 26.1048 9	(48) 52.2096 17
Measuring & Recording Output - Drainage Bottles, All Types (1.6962)	(3) 5.0886 2	(6) 10.1772 3	(9) 15.2658 5	(12) 20.3544 7	(24) 40.7088 14	(48) 81.4176 27
Giving a Bedpan (2.5998)	(1) 2.5998 1	(2) 5.1996 2	(3) 7.7994 3	(6) 15.5988 5	(9) 23.3982 8	(12) 31.1976 10
Giving a Urinal (1.9695)	(1) 1.9695 .5	(2) 3.9390 1	(3) 5.9085 2	(6) 11.8170 4	(9) 17.7255 6	(12) 23.6340 8
Incontinent Care (7.1308)	(1) 7.1308 2	(2) 14.2616 5	(3) 21.3924 7	(6) 42.7848 14	(9) 64.1772 21	(12) 85.5696 29
<u>MOBILITY/EXERCISE/SAFETY:</u>						
Changing Patient's Position in Bed (2.1226)	(3) 6.3678 2	(6) 12.7356 4	(9) 19.1034 6	(12) 25.4712 8	(18) 38.2068 13	(24) 50.9424 17
Adjusting Position of Bed (.7158)	(3) 2.1474 1	(6) 4.2948 1	(9) 6.4422 2	(12) 8.5896 3	(18) 12.8844 4	(24) 17.1792 6
Adjusting Siderail (.3696)	(3) 1.1088 .5	(6) 2.2176 1	(12) 4.4352 1	(24) 8.8704 3	(48) 17.7408 6	(96) 35.4816 12

Table 5

Category of Care by Age Group for Rater One vs Rater Two
N = 584

		Age Group								
		1	2	3	4	5	6	7	8	9
Category of Care	1	Rater One	0	0	0	0	0	1	0	0
		Rater Two	0	0	0	0	2	1	0	0
	2	Rater One	0	0	0	3	10	33	25	9
		Rater Two	0	0	0	3	12	36	25	9
	3	Rater One	3	1	3	3	31	69	51	16
		Rater Two	3	0	2	3	26	75	55	18
	4	Rater One	4	3	1	4	17	53	46	24
		Rater Two	5	3	1	3	20	50	42	23
	5	Rater One	4	0	3	0	21	43	32	29
		Rater Two	3	1	4	1	22	46	31	31
	6	Rater One	0	0	0	0	1	1	3	3
		Rater Two	0	0	0	0	0	0	3	0

Age Groups: 1 = less than 3 years
 2 = 3 thru 5 years
 3 = 6 thru 11 years
 4 = 12 thru 15 years
 5 = 16 thru 25 years
 6 = 26 thru 55 years
 7 = 56 thru 65 years
 8 = 66 thru 75 years
 9 = 76 thru 100 years

The breakdown of category of care by sex of the patient for rater one vs rater two is shown in Table 6.

Table 6

Category of Care by Sex of the Patient for Rater One vs Rater Two

		Sex of Patient	
		Male	Female
1	Rater One	0	1
	Rater Two	1	2
2	Rater One	65	23
	Rater Two	66	22
3	Rater One	119	66
	Rater Two	127	64
4	Rater One	95	70
	Rater Two	85	69
5	Rater One	85	52
	Rater Two	89	55
6	Rater One	7	1
	Rater Two	3	1
N		371	213

The descriptive data of the patient care indicator scores for rater one vs rater two by sex of total population are shown in Table 7.

Table 7

Descriptive Data of Patient Care Indicator Scores
for Rater One vs Rater Two by Sex

		Mean	SD	N
Male	Rater One	181.88	110.23	371
	Rater Two	180.55	89.19	
Female	Rater One	187.73	90.58	213
	Rater Two	184.20	89.19	

The distribution of the categories of care by days of the week for rater one vs rater two are shown in Table 8.

Table 8

Category of Care by Days of the Week for Rater One vs Rater Two
N = 584

		Days of Week						
		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Category of Care	1	Rater One Rater Two	0 0	1 1	0 0	0 1	0 0	0 0
	2	Rater One Rater Two	11 11	12 10	23 21	15 15	7 12	9 10
	3	Rater One Rater Two	18 22	32 38	21 23	21 24	36 29	26 22
	4	Rater One Rater Two	27 25	28 22	30 27	8 7	35 30	18 24
	5	Rater One Rater Two	24 21	24 27	12 16	16 14	20 29	22 18
	6	Rater One Rater Two	0 1	1 0	3 2	0 0	2 0	1 1

In the determination of interrater reliability two sets of ratings, one for total score and one for category of care were obtained from the assessment of each of the 584 inpatients by two independently trained raters representing four medical treatment facilities. These data were analyzed using the Pearson's correlation coefficient with a resultant reliability coefficient for total score and category of care. Table 9 displays the critical care patient classification instrument frequency distribution: rater one vs rater two for category of care. Pearson's r for category of care rater one vs rater two, $r = .90$.

Table 9

Critical Care Patient Classification Instrument
Frequency Distribution: Rater One vs Rater Two for Category of Care
N = 584

		Category of Care for Rater Two				
		2	3	4	5	6
Category of Care for Rater One	2	78	8	8	0	0
	3	10	155	17	3	0
	4	0	26	118	21	0
	5	0	2	19	114	2
	6	0	0	0	6	2

Pearson's r for category of care rater one vs rater two, $r = .90$.

Concurrently, Table 10 displays the correlation coefficient for total patient care indicator score (PCIS) by category of care. Pearson's r for total PCIS rater one vs rater two across categories, $r = .91$. All coefficients for total score and category of care were significant ($p < .001$).

Table 10

Critical Care Patient Classification Instrument
Total Patient Care Indicator Score (PCIS) by Category of Care

		PCIS	Mean	SD	95% CI	N	
Category of Care	2	Rater One Rater Two	40-79	62.38 63.46	10.47 10.31	60.16-64.59 61.17-65.75	88 88
	3	Rater One Rater Two	80-159	113.55 117.04	24.96 26.04	114.93-122.17 113.32-120.76	185 191
	4	Rater One Rater Two	160-239	198.47 196.53	22.36 24.15	194.95-201.98 192.68-200.37	165 154
	5	Rater One Rater Two	240-499	312.37 316.41	60.19 65.62	302.20-322.54 305.60-327.22	137 144
	6	Rater One Rater Two	500-720	557.86 538.38	39.79 45.10	524.61-591.14 466.62-610.13	3 4

Pearson's r for total PCIS rater one vs rater two across categories, $r = .91$.

To establish internal consistency of the critical care patient classification instrument two independent raters' patient care indicator scores were analyzed to determine if the individual responses to the various patient care indicators were consistent. Correlation coefficients were used to indicate the degree to which variation in the patient care indicator scores for rater one was related to variation in the patient care indicator scores for rater two. Significance tests for each coefficient were derived from the students t with $N-2$ degrees of freedom. Correlation coefficients and tests of significance for rater one vs rater two for each patient care indicator across categories of care are shown in Table 11. All of the coefficients except three were significant at the .05 level or better. Moreover, it is worthy to note that the three coefficients which did not achieve significance were based on $df = 4$ which lessens the power of the test considerably.

E. CONCLUSIONS

The critical care patient classification subsystem has been developed and tested through four years of rigorous field research. This quantitative subsystem measures direct nursing care activities and determines the best mix by skill level of care providers for critical care. The critical care patient classification subsystem utilizes the factor-evaluation design, is multidimensional, and is designed for automated or manual implementation. Extensive validity and reliability studies demonstrate that the critical care patient classification subsystem is valid and reliable.

TABLE 11
CRITICAL CARE PATIENT CLASSIFICATION INSTRUMENT
INTERCORRELATIONS OF PATIENT CARE INDICATOR SCORES

	Hygiene	Nutrition/ Elimination	Mobility/ Exercise/ Safety	Medication Tests	Vital Signs /Assessment/ Diagnostic Tests	Psychological/ Patient Teaching	Gastrointestinal	Respiratory	Cardiovascular/ Temperature/Regulation	Skin	Skeletal/ Neurological/ ENT	Urological/ Gynecological	Other Therapeutic Activities/ Modalities
Category 3 (4-7 hours) (df = 138)	r=.752 p<.001	r=.777 p<.001	r=.588 p<.001	r=.896 p<.001	r=.373 p<.001	r=.463 p<.001	r=.811 p<.001	r=.866 p<.001	r=.737 p<.001	r=.676 p<.001	r=.617 p<.001	r=.761 p<.001	r=.524 p<.001
Category 4 (8-11 hours) (df = 106)	r=.709 p<.001	r=.655 p<.001	r=.598 p<.001	r=.874 p<.001	r=.720 p<.001	r=.386 p<.001	r=.893 p<.001	r=.837 p<.001	r=.755 p<.001	r=.765 p<.001	r=.608 p<.001	r=.757 p<.001	r=.356 p<.001
Category 5 (12-24 hours) (df = 97)	r=.688 p<.001	r=.750 p<.001	r=.622 p<.001	r=.601 p<.001	r=.701 p<.001	r=.600 p<.001	r=.511 p<.001	r=.685 p<.001	r=.784 p<.001	r=.819 p<.001	r=.755 p<.001	r=.530 p<.001	r=.765 p<.001
Category 6 (25-36+ hours) (df = 4)	r=.925 p<.01	r=.580 p n/s	r=.108 p n/s	r=.800 p<.05	r=.948 p<.01	r=.736 p<.10	r=.027 p<.05	r=.073 p<.05	r=.803 p<.05	r=.969 p<.01	r=.860 p<.05	r=.323 p n/s	r=.878 p<.05

APPENDIX A

Critical Care Patient Classification Instrument Mathematical Model

CRITICAL CARE PATIENT CLASSIFICATION INSTRUMENT

MATHEMATICAL MODEL

ACTIVITY
(MEAN)
(FREQUENCY)
TOTAL SCORE
WEIGHTED SCORE

HYGIENE:

Bathing, Complete (20.1646)	(1) 20.1646 7	(2) 40.3292 13	(3) 60.4938 20	(4) 80.6584 27	(5) 100.8230 34	(6) 120.9876 40
Bathing, Assis with Back & Legs (12.1010)	(1) 12.1010 4					
AM Care (6.9666)	(1) 6.9666 2					
AM Care, Partial (4.3378)	(1) 4.3378 1					
Oral Hygiene (3.2428)	(1) 3.2428 1	(3) 9.7284 3	(6) 19.4568 6	(9) 29.1852 10	(12) 38.9136 13	(24) 77.8272 26
Skin Care/ Back Rub (3.3675)	(1) 3.3675 1	(3) 10.1025 3	(6) 20.2050 7	(9) 30.3075 10	(12) 40.4100 13	(24) 80.8200 27
PM Care (10.6934)	(1) 10.6934 4					
Shaving (6.2501)	(1) 6.2501 2					
Occupied Bed (9.6977)	(1) 9.6977 3	(2) 19.3954 6	(3) 29.0931 10	(4) 38.7908 13	(5) 48.4885 16	(6) 58.1862 19
Unoccupied Bed (6.0472)	(1) 6.0472 2	(2) 12.0944 4	(3) 18.1416 6			
Changing Bed Linen Protector/Chux (1.0063)	(3) 3.0189 1	(6) 6.0378 2	(9) 9.0567 3	(12) 12.0756 4	(18) 18.1134 6	(24) 24.1512 8

NUTRITION/ELIMINATION:

Fluid/Snack (.8999)	(1) .8999 .5	(3) 2.6997 1	(6) 5.3994 2	(9) 8.0991 3	(12) 10.7988 4	(24) 21.5976 7
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ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE					
Adjusting Restraint (1.2751)	(3) 3.8253 1	(6) 7.6506 3	(12) 15.3012 5	(24) 30.6024 10	(48) 61.2048 20	(96) 122.4096 41
Exercise - Active/ Passive (6.5687)	(1) 6.5687 2	(2) 13.1374 4	(3) 19.7061 7	(6) 39.4122 13	(9) 59.1183 20	(12) 79.8244 26
Mobility - Bed to Stretcher/Bed to Chair/ Ambulating First Time (4.9972)	(1) 4.9972 2	(2) 9.9944 3	(3) 14.9916 5	(6) 29.9832 10	(9) 44.9748 15	(12) 59.9664 20
Mobility - Assistance While Walking/Bedside Commode (3.7348)	(1) 3.7348 1	(2) 7.4696 2	(3) 11.2044 4	(6) 22.4088 7	(9) 33.6132 11	(12) 44.8176 15
Mobility - Bed to Floor/ Sitting on Side of Bed (1.7997)	(1) 1.7997 .5	(2) 3.5994 1	(3) 5.3991 2	(6) 10.7982 4	(9) 16.1973 5	(12) 21.5964 7
Turning Frame, All Types (9.0256)	(1) 9.0256 3	(2) 18.0512 6	(3) 27.0768 9	(6) 54.1536 18	(9) 81.2304 27	(12) 108.3072 36

MEDICATION:

Oral (.8085)	(1) .8085 .5	(3) 2.4255 1	(6) 4.8510 2	(9) 7.2765 2	(12) 9.7020 3	(24) 19.4040 6
Topical (1.2234)	(1) 1.2234 .5	(3) 3.6702 1	(6) 7.3404 2	(9) 11.0106 4	(12) 14.6808 5	(24) 29.3616 10
Intramuscular (1.2259)	(1) 1.2259 .5	(2) 2.4518 1	(3) 3.6777 1	(4) 4.9036 2	(6) 7.3554 2	(8) 9.8072 3
Subcutaneous (.9010)	(1) .9010 .5	(2) 1.8020 .5	(3) 2.7030 1	(4) 3.6040 1	(6) 5.4060 1	(8) 7.2080 2
Sublingual (.4778)	(1) .4778 .5	(2) .9556 .5	(3) 1.4334 .5	(4) 1.9112 .5	(6) 2.8668 1	(8) 3.8224 1
Suppository, Rectal/Vaginal (1.4799)	(1) 1.4799 .5	(2) 2.9598 1	(3) 4.4397 1	(4) 5.9196 2	(6) 8.8794 3	(8) 11.8392 4

ACTIVITY
(MEAN)

(FREQUENCY)
TOTAL SCORE
WEIGHTED SCORE

VITAL SIGNS/ASSESSMENT/DIAGNOSTIC TESTS:

Blood Pressure, Manual (1.0388)	(3) 3.1164 1	(6) 6.2328 2	(12) 12.4656 4	(24) 24.9312 8	(48) 49.8624 17	(96) 99.7248 33
Pulse - Radial/Brachial/ Pedal/Femoral/Popliteal (.8520)	(3) 2.5560 1	(6) 5.1120 2	(12) 10.2240 3	(24) 20.4480 7	(48) 40.8960 14	(96) 81.7920 27
Pulse - Apical (1.3296)	(3) 3.9888 1	(6) 7.9776 3	(12) 15.9552 5	(24) 31.9104 11	(48) 63.8208 21	(96) 127.6416 43
Respirations (.6727)	(3) 2.0181 1	(6) 4.0362 1	(12) 8.0724 3	(24) 16.1448 6	(48) 32.2896 11	(96) 64.5792 22
Oral Temperature, Pulse and Respirations (1.2903)	(3) 3.8709 1	(6) 7.7418 3	(9) 11.6127 4	(12) 15.4836 5	(18) 23.2254 8	(24) 30.9672 10
Temperature - Oral/ Rectal/Axillary (1.2370)	(3) 3.7110 1	(6) 7.4220 2	(9) 11.1330 4	(12) 14.8440 5	(18) 22.2660 7	(24) 29.6880 10
Rhythm Strip - Monitor (.8610)	(3) 2.5830 1	(6) 5.1660 2	(9) 7.7490 3	(12) 10.3320 3	(18) 15.4980 5	(24) 20.6640 7
Rhythm Strip - ECG Machine (7.7785)	(3) 23.3355 8	(6) 46.6710 16	(9) 70.0065 23	(12) 93.3420 31	(18) 140.0130 47	(24) 186.6840 62
Rhythm Strip Measurements (1.3743)	(3) 4.1229 1	(6) 8.2458 3	(9) 12.3687 4	(12) 16.4916 5	(18) 24.7374 8	(24) 32.9832 11
Pulmonary Artery Pressure Wedge (1.4316)	(3) 4.2948 1	(6) 8.5896 3	(9) 12.8844 4	(12) 17.1792 6	(18) 25.7688 9	(24) 34.3584 11
Central Venous Pressure (2.3433)	(3) 7.0299 2	(6) 14.0598 5	(9) 21.0894 7	(12) 28.1196 9	(18) 42.1794 14	(24) 56.2392 19
Monitor Reading of Blood Pressure/Heart Rate - Rhythm/Pulmonary Artery or Central Venous Pressure (.6506)	(6) 3.9036 1	(12) 7.8072 3	(24) 15.6144 5	(48) 31.2288 10	(96) 62.4576 21	(120) 78.0720 26
Adjusting Cardiac Monitor/ Connecting Leads/Reset Alarm (.9458)	(3) 2.8374 1	(6) 5.6748 2	(12) 11.3496 4	(24) 22.6992 8	(48) 45.3984 15	(96) 90.7968 30

ACTIVITY (MEAN)	(FREQUENCY)					
	TOTAL SCORE		WEIGHTED SCORE			
Abdominal Girth Measurement (2.0905)	(1) 2.0905 1	(2) 4.1810 1	(3) 6.2715 2	(6) 12.5430 4	(9) 18.8145 6	(12) 25.0860 8
Extremity Circumference Measurement (.7655)	(1) .7655 .5	(2) 1.5310 .5	(3) 2.2965 1	(6) 4.5930 2	(9) 6.8895 2	(12) 9.1860 3
Monitor Leads Application/Exchange (2.1090)	(1) 2.1090 1	(2) 4.2180 1	(3) 6.3270 2	(6) 12.6540 4	(9) 18.9810 6	
Cardiac Output Measurement (5.8300)	(1) 5.8300 2	(2) 11.6600 4	(3) 17.4900 6	(6) 34.9800 12		
Heart Sounds Assessment (1.2845)	(1) 1.2845 .5	(2) 2.5690 1	(3) 3.8535 1	(4) 5.1380 2	(5) 6.4225 2	(6) 7.7070 3
12 Lead ECG (10.3289)	(1) 10.3289 3	(2) 20.6578 7	(3) 30.9867 10	(4) 41.3156 14	(5) 51.6445 17	(6) 61.9734 21
Bed Scale Weight (5.6879)	(1) 5.6879 2	(2) 11.3758 4	(3) 17.0637 6			
Ambulatory Weight (1.2309)	(1) 1.2309 .5	(2) 2.4618 1				
Mental Alertness (.9056)	(3) 2.7168 1	(6) 5.4336 2	(9) 8.1504 3	(12) 10.8672 4	(18) 16.3008 5	(24) 21.7344 7
Orientation (.9941)	(3) 2.9823 1	(6) 5.9646 2	(9) 8.9469 3	(12) 11.9292 4	(18) 17.8938 6	(24) 23.8584 8
Pupil Reflexes (.6611)	(3) 1.9833 .5	(6) 3.9666 1	(9) 5.9499 2	(12) 7.9332 3	(18) 11.8998 4	(24) 15.8664 5
Motor/Sensory Testing (1.1761)	(3) 3.5283 1	(6) 7.0566 2	(9) 10.5849 4	(12) 14.1132 5	(18) 21.1698 7	(24) 28.2264 9
Pulmonary Assessment (1.5927)	(3) 4.7781 2	(6) 9.5562 3	(9) 14.3343 5	(12) 19.1124 6	(18) 28.6686 10	(24) 38.2248 13
Bowel Sound Assessment (1.5112)	(3) 4.5336 2	(6) 9.0672 3	(9) 13.6008 5	(12) 18.1344 6		

ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE					
Urine Testing - Protein (.6307)	(3) 1.8921 .5	(6) 3.7842 1	(9) 5.6763 2	(12) 7.5684 3	(18) 11.3526 4	(24) 15.1368 5
Urine Testing - Specific Gravity (.8422)	(3) 2.5766 1	(6) 5.0532 2	(9) 7.5798 3	(12) 10.1064 3	(18) 15.1596 5	(24) 20.2128 7
Urine Testing - Sugar & Acetone (1.7777)	(3) 5.3331 2	(6) 10.6662 4	(9) 15.9993 5	(12) 21.3324 7	(18) 31.9986 11	(24) 42.6648 14
Guaiac Testing - Feces/Vomit/GI Drainage (1.0702)	(3) 3.2106 1	(6) 6.4212 2	(9) 9.6318 3	(12) 12.8424 4	(18) 19.2636 6	(24) 25.6848 8
Hematocrit (3.7683)	(1) 3.7683 1	(2) 7.5366 3	(3) 11.3049 4	(4) 15.0732 5	(6) 22.6098 8	(9) 33.9147 11
Situational Observation (28.2544)	(1) 28.2554 9	(2) 56.5108 19	(3) 84.7662 28			
<u>PSYCHOLOGICAL/PATIENT TEACHING:</u>						
Answering Patient's Question (1.0121)	(1) 1.0121 .5	(2) 2.0242 1	(3) 3.0363 1	(6) 6.0726 2	(12) 12.1452 4	(24) 24.2904 8
Orientation to Clinical Unit (4.7997)	(1) 4.7997 2	(2) 9.5994 3	(3) 14.3991 5			
Visiting with Patient/ Purposeful Interaction (2.1036)	(3) 6.3108 2	(6) 12.6216 4	(9) 18.9324 6	(12) 25.2432 8	(24) 50.4864 17	(48) 100.9728 34
Explanation of Procedures/Tests (1.7433)	(3) 5.2299 2	(6) 10.4598 3	(9) 15.6897 5	(12) 20.9196 7	(24) 41.8392 14	(48) 83.6784 28
Teaching - Diagnostic Test (1.0804)	(1) 1.0804 .5	(2) 2.1608 1	(3) 3.2412 1	(4) 4.3216 1	(5) 5.4020 2	(6) 6.4824 2
Teaching - Dietary Explanation (2.8633)	(1) 2.8633 1	(2) 5.7266 2	(3) 8.5899 3	(4) 11.4532 4	(5) 14.3165 5	(6) 17.1798 6
Teaching - Blow Bottles/ Incentive Spirometer (3.5971)	(1) 3.5971 1	(2) 7.1942 2	(3) 10.7913 4	(4) 14.3884 5	(5) 17.9855 6	(6) 21.5826 7

ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE						
Teaching - Medication Administration (19.5881)	(1) 19.5881 7						
Teaching - Disease/ Condition Related (6.1507)	(1) 6.1507 2	(2) 12.3014 4	(3) 18.4521 6	(6) 36.9042 12	(9) 55.3563 18	(12) 73.8084 25	

GASTROINTESTINAL:

Nasogastric Tube - Instillation (2.4201)	(1) 2.4201 1	(3) 7.2603 2	(6) 14.5206 5	(9) 21.7809 7	(12) 29.0412 10	(24) 58.0824 19	
Nasogastric Tube - Irrigation (1.5874)	(1) 1.5874 .5	(3) 4.7622 2	(6) 9.5244 3	(9) 14.2866 5	(12) 19.0488 6	(24) 38.0976 13	
Nasogastric Tube - Insertion (8.0006)	(1) 8.0006 3	(2) 16.0012 5	(3) 24.0018 8	(4) 32.0024 11	(5) 40.0030 13	(6) 48.0036 16	
Nasogastric Tube - Removal (1.4648)	(1) 1.4648 .5	(2) 2.9296 1					
Rectal Tube Insertion/ Removal or Fecal Impaction Assessment/Removal (3.2146)	(1) 3.2146 1	(2) 6.4292 2	(3) 9.6438 3				
Dressing Change - Colostomy/Ileostomy/ Ileoconduit (8.1367)	(1) 8.1367 3	(2) 16.2734 5	(3) 24.4101 8	(4) 32.5468 11	(5) 40.6835 14	(6) 48.8202 16	

RESPIRATORY:

Oxygen Administration (1.0541)	(3) 3.1623 1	(6) 6.3246 2	(9) 9.4869 3	(12) 12.6492 4	(24) 25.2984 8	(48) 50.5968 17	
Suctioning - Oral (1.6606)	(3) 4.9818 2	(6) 9.9636 3	(9) 14.9454 5	(12) 19.9272 7	(18) 29.8908 10	(24) 39.8544 13	
Suctioning - Endotracheal/ Tracheostomy/Naso-Tracheal (3.3998)	(3) 10.1994 3	(6) 20.3988 7	(9) 30.5982 10	(12) 40.7976 14	(18) 61.1964 20	(24) 81.5952 27	
Cough and Deep Breathe (2.2805)	(3) 6.8415 2	(6) 13.6830 5	(9) 20.5245 7	(12) 27.3660 9	(18) 41.0490 14	(24) 54.7320 18	
Chest Pulmonary Therapy - Frappage with Postural Drainage (3.6600)	(3) 10.9800 4	(6) 21.9600 7	(9) 32.9400 11	(12) 43.9200 15	(18) 65.8800 22	(24) 87.8400 29	

ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE					
Tracheostomy - Cleaning Cannula/Dressing Change (6.2021)	(3) 18.6063 6	(6) 37.2126 12	(9) 55.8189 19	(12) 74.4252 25		
Blow Bottles/ Incentive Spirometer (3.2065)	(3) 9.6195 3	(6) 19.2390 6	(9) 28.8585 10	(12) 38.4780 13		
IPPB Treatment (7.9892)	(3) 23.9676 8	(6) 47.9352 16	(9) 71.9028 24	(12) 95.8704 32		
Positioning for X-Ray (3.7549)	(1) 3.7549 1	(2) 7.5098 3	(3) 11.2647 4	(4) 15.0196 5	(5) 18.7745 6	(6) 22.5294 8
Chest Tube - Care (11.4078)	(1) 11.4078 4	(2) 22.8156 8	(3) 34.2234 11	(4) 45.6312 15		
Chest Tube - Changing Bottles (9.4762)	(1) 9.4762 3	(2) 18.9524 6	(3) 28.4286 9			
Chest Tube - Insertion (27.4300)	(1) 27.4300 9	(2) 54.8600 18				
Chest Tube - Removal (5.6418)	(1) 5.6418 2	(2) 11.2836 4				
Intubation (17.3291)	(1) 17.3291 6	(2) 34.6582 12				
Extubation (2.5567)	(1) 2.5567 1					

CARDIOVASCULAR/TEMPERATURE REGULATION:

Venipuncture - Blood Sample (3.5175)	(1) 3.5175 1	(2) 7.0350 2	(3) 10.5525 4	(6) 21.1050 7	(9) 31.6575 11	(12) 42.2100 14
Venipuncture - Blood Culture (4.9744)	(1) 4.9744 2	(2) 9.9488 3	(3) 14.9232 5			
Arterial Puncture - Blood Gases (5.4707)	(3) 16.4121 5	(6) 32.8242 11	(9) 49.2363 16	(12) 65.6484 22	(18) 98.4726 33	(24) 131.2968 44
Intravenous/Arterial Line - Blood Sample (2.8946)	(3) 8.6838 3	(6) 17.3676 6	(9) 26.0514 9	(12) 34.7352 12	(18) 52.1028 18	(24) 69.4704 23

ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE					
IV Infusion - Changing IV Bottle (1.6528)	(3) 4.9584 2	(6) 9.9168 3	(9) 14.8752 5	(12) 19.8336 7	(18) 29.7504 10	(24) 39.6672 13
IV Infusion - Initiating/ IV Catheter Care (9.5417)	(1) 9.5417 3	(2) 19.0834 6	(3) 28.6251 10	(6) 57.2502 19	(9) 85.8753 29	(12) 114.5004 38
IV Infusion - Infusion Pump Setup/IV or Arterial Line Termination (3.4434)	(1) 3.4434 1	(3) 10.3302 3	(6) 20.6604 7	(12) 41.3208 14	(18) 61.9812 21	(24) 82.6416 28
IV Infusion - IV Push Medication/Piggy-Back Medication (1.8793)	(1) 1.8793 .5	(3) 5.6379 2	(6) 11.2758 4	(12) 22.5516 8	(24) 45.1032 15	(48) 90.2064 30
IV Infusion - Platelets/ Plasma/Blood (3.3270)	(1) 3.3270 1	(3) 9.9810 3	(6) 19.9620 7	(12) 39.9240 13	(24) 79.8480 27	(48) 159.6960 53
IV Infusion - Flow Rate (.7528)	(12) 9.0336 3	(24) 18.0672 6	(48) 36.1344 12	(96) 72.2688 24	(120) 90.3360 30	(144) 108.4032 36
Arterial Line - Transducer Exchange (16.3290)	(1) 16.3290 5	(2) 32.6580 11	(3) 48.987 16			
Arterial Line - Setup (17.1862)	(1) 17.1862 6	(2) 34.3724 11				
Arterial Line - Initiation (42.1319)	(1) 42.1319 14	(2) 84.2638 28				
Arterial Line - Swan Ganz Catheter Setup (33.3120)	(1) 33.3120 11	(2) 66.6240 22				
Swan Ganz Catheter - Initiation (41.1012)	(1) 41.1012 14	(2) 82.2024 27				
Swan Ganz Catheter - Removal (6.8900)	(1) 6.8900 2					
Elastic Stockings/ Ace Bandage (3.4471)	(1) 3.4471 1	(2) 6.8942 2	(3) 10.3413 3	(4) 13.7884 5	(5) 17.2355 6	(6) 20.6826 7
Cardiopulmonary Resuscitation (62.2733)	(1) 62.2733 21	(2) 124.5466 42	(3) 186.8199 62	(4) 249.0932 83	(5) 311.3665 104	(6) 373.6398 124

ACTIVITY (MEAN)	(FREQUENCY)	
	TOTAL SCORE	WEIGHTED SCORE
Hypothermia/ Hyperthermia Treatment (5.3302)	(1) 5.3302 2	(2) 10.6604 4
Cardioversion (22.7450)	(1) 22.7450 8	(2) 45.4900 15
External Pacemaker (10.0250)	(1) 10.0250 3	(2) 20.0500 7

SKIN:

Small Dressing Change ($<4'' \times 8''$)/Suture or Skin Clip Removal (<15) (6.3355)	(1) 6.3355 2	(2) 12.6710 4	(3) 19.0065 6	(6) 38.0130 13	(9) 57.0195 19	(12) 76.0260 25
Large Dressing Change ($\geq 4'' \times 8''$)/Wound Irrigation/Local Surgical Prep (11.3649)	(1) 11.3649 4	(2) 22.7298 8	(3) 34.0947 11	(6) 68.1894 23	(9) 102.2841 34	(12) 136.3788 45
Reinforcing Dressing (3.5442)	(1) 3.5442 1	(2) 7.0884 2	(3) 10.6326 4	(6) 21.2652 7	(9) 31.8978 11	(12) 42.5304 14
Hot Compress/Wound Culture (2.5428)	(1) 2.5428 1	(2) 5.0856 2	(3) 7.6284 3	(6) 15.2568 5	(9) 22.8852 8	(12) 30.5136 10
Decubitus Care/ Cold Compress (8.0521)	(1) 8.0521 3	(2) 16.1042 5	(3) 24.1563 8	(6) 48.3121 16	(9) 72.4689 24	(12) 96.6252 32
Application of K-Pad/ Heat Lamp (1.2879)	(1) 1.2879 .5	(2) 2.5758 1	(3) 3.8637 1	(6) 7.7274 3	(9) 11.5911 4	(12) 15.4548 5
Suture or Skin Clip Removal (≥ 15) (14.4313)	(1) 14.4313 5	(2) 28.8626 10	(3) 43.2939 14			
Air Floatation/Alter- nating Pressure Mattress (6.5762)	(1) 6.5762 2					
Isolation, Gowning and Gloving (1.4659)	(6) 8.7954 3	(12) 17.5908 6	(24) 35.1816 12	(48) 70.3632 23	(72) 105.5448 35	(96) 140.7264 47

ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE
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SKELETAL/NEUROLOGICAL/ENT:

Pin/Head Tongs Care (6.7835)	(1) 6.7835 2	(2) 13.5670 5	(3) 20.3505 7	(4) 27.1340 9	(5) 33.9175 11	(6) 40.7010 14
Extremity Traction - Application (4.1400)	(1) 4.1400 1	(2) 8.2800 3	(3) 12.4200 4	(6) 24.8400 8	(9) 37.2600 12	(12) 49.6800 17
Extremity Traction - Adjust (2.5445)	(1) 2.5445 1	(2) 5.0890 2	(3) 7.6335 3	(6) 15.2670 5	(9) 22.9005 8	(12) 30.5340 10
Extremity Elevation (.9140)	(1) .9140 .5	(3) 2.7420 1	(6) 5.4840 2	(9) 8.2260 3	(12) 10.9680 4	(24) 21.9360 7
Cast Care (1.1165)	(1) 1.1165 .5	(3) 3.3495 1	(6) 6.6990 2	(9) 10.0485 3	(12) 13.3980 4	(24) 26.7960 9
Ice Pack (.8001)	(1) .8001 .5	(3) 2.4003 1	(6) 4.8006 2	(9) 7.2009 2	(12) 9.6012 3	(24) 19.2024 6
Eye Care (1.7834)	(1) 1.7834 .5	(3) 5.3502 2	(6) 10.7004 4	(9) 16.0506 5	(12) 21.4008 7	(24) 42.8016 14
Instillation of Drops - Eye/Ear/Nose (.5992)	(1) .5992 .5	(3) 1.7976 .5	(6) 3.5952 1	(9) 5.3928 2	(12) 7.1904 2	(24) 14.3808 5
Culture - Sputum (2.4563)	(1) 2.4563 1	(2) 4.9126 2	(3) 7.3689 2			
Culture - Nose/ Throat (.4417)	(1) .4417 .5	(2) .8834 .5				
Circulation Check (.6672)	(6) 4.0032 1	(12) 8.0064 3	(24) 16.0128 5	(48) 32.0256 11	(96) 64.0512 21	(120) 80.0640 27

UROLOGICAL/GYNECOLOGICAL:

Foley Catheter Care/ Foley Catheter Removal/ Condom Catheter Applica- tion/Bladder Irrigation (3.7435)	(1) 3.7435 1	(2) 7.4870 2	(3) 11.2305 4	(6) 22.4610 7	(9) 33.6915 11	(12) 44.9220 15
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ACTIVITY
(MEAN)

(FREQUENCY)
TOTAL SCORE
WEIGHTED SCORE

Perineal Care (2.3750)	(1) 2.3750 1	(2) 4.7500 2	(3) 7.1250 2	(6) 14.2500 5	(9) 21.3750 7	(12) 28.5000 10
Changing Perineal Pad (.7891)	(1) .7891 5	(2) 1.5782 .5	(3) 2.3673 1	(6) 4.7346 2	(9) 7.1019 2	(12) 9.4692 3
Urine Specimen - Clean Catch/Foley Catheter (2.0660)	(1) 2.0660 1	(2) 4.1320 1	(3) 6.1980 2	(4) 8.2640 3	(5) 10.3300 3	(6) 12.3960 4
Urine Specimen - Routine (1.6880)	(1) 1.6880 .5	(2) 3.3760 1	(3) 5.0640 2			
Catheterization - Foley (7.9674)	(1) 7.9674 3	(2) 15.9348 5				

APPENDIX B
Critical Care Patient Classification Instrument

a. Patient's Hospital Card

CRITICAL CARE PATIENT CLASSIFICATION INSTRUMENT

TOTAL PCIS Points	WEIGHTED SCORE (Points)	CATEGORY (Circle One)
<div style="border: 1px solid black; width: 50px; height: 20px; display: inline-block;"></div>	>40 - 79	2
	80 - 159	3
	160 - 239	4
	240 - 499	5
	500 - 720	6

b. Date: _____ c. Rater's Name: _____

HYGIENE

	FREQUENCY	1	2	3	4	5	6
Bathing, Complete	SCORE	7	13	20	27	34	40
Bathing, Assist with Back & Legs		4					
AM Care		2					
AM Care, Partial		1					
Oral Hygiene		1	3	6	9	12	24
Skin Care/Back Rub		1	3	7	10	13	27
PM Care		4					
Shaving		2					
Occupied Bed		3	6	10	13	16	19
Unoccupied Bed		2	4	6			
Changing Bed Linen Protector/Chux		3	6	9	12	18	24
		1	2	3	4	6	8

PCIS .
13-15 16

NUTRITION/ELIMINATION

	FREQUENCY	1	3	6	9	12	24
Fluid /Snack	SCORE	.5	1	2	3	4	7
Feeding		1	2	3			
Serving Meal Tray, with Preparation		5	11	16			
		1	2	3			
Special Feeding - Hyperalimentation, IV		1	2	3	4	6	8
Special Feeding - Nasogastric/Gastrostomy		2	4	6	8	12	16
		1	2	4	5	7	10
Measuring & Recording Intake		3	6	9	12	18	24
		1	2	3	3	5	7
Measuring & Recording Output - Urine/Liquid Feces/Vomit/Diaper or Bed Linens		3	6	9	12	24	48
		1	2	3	4	9	17
Measuring & Recording Output - Drainage Bottles, All Types		2	3	5	7	14	27
Giving a Bedpan		1	2	3	6	9	12
Giving a Urinal . . . . .		.5	1	2	4	6	8
Incontinent Care		2	5	7	14	21	29

PCIS .
17-19 20

MOBILITY/EXERCISE/SAFETY

	FREQUENCY	3	6	9	12	18	24
Changing Patient's Position in Bed	SCORE	2	4	6	8	13	17
Adjusting Position of Bed		1	1	2	3	4	6
Adjusting Siderail		3	6	12	24	48	96
Adjusting Restraint . . . . .		.5	1	1	3	6	12
		1	3	5	10	20	41
Exercise - Active/Passive		1	2	3	6	9	12
Mobility - Bed to Stretcher/Bed to Chair/ Ambulating First Time		2	4	7	13	20	26
Mobility - Assistance While Walking/ Bedside Commode		2	3	5	10	15	20
Mobility - Bed to Floor/Sitting on Side of Bed		1	2	4	7	11	15
Turning Frame, All Types . . . . .		.5	1	2	4	5	7
		3	6	9	18	27	36

PCIS .
21-23 24

MEDICATION

	FREQUENCY	1	3	6	9	12	24
Oral	SCORE	.5	1	2	2	3	6
Topical . . . . .		.5	1	2	4	5	10
Intramuscular		1	2	3	4	6	8
Subcutaneous . . . . .		.5	1	1	2	2	3
Sublingual . . . . .		.5	.5	1	1	1	2
Suppository, Rectal/Vaginal . . . . .		.5	.5	.5	.5	1	1
		.5	1	1	2	3	4

PCIS .
25-27 28

VITAL SIGNS/ASSESSMENT/DIAGNOSTIC TESTS

	FREQUENCY	3	6	12	24	48	96
Blood Pressure, Manual	SCORE	1	2	4	8	17	33
Pulse - Radial/Brachial/Pedal/ Femoral/Popliteal		1	2	3	7	14	27
Pulse - Apical.		1	3	5	11	21	43
Respirations.		1	1	3	6	11	22

	3	6	9	12	18	24
Oral Temperature, Pulse, & Respirations	1	3	4	5	8	10
Temperature - Oral/Rectal/Axillary.	1	2	4	5	7	10
Rhythm Strip - Monitor.	1	2	3	3	5	7
Rhythm Strip - ECG Machine.	8	16	23	31	47	62
Rhythm Strip Measurements	1	3	4	5	8	11
Pulmonary Artery Pressure Wedge	1	3	4	6	9	11
Central Venous Pressure	2	5	7	9	14	19

	6	12	24	48	96	120
Monitor Reading of Blood Pressure/Heart Rate - Rhythm/Pulmonary Artery or Central Venous Pressure.	1	3	5	10	21	26

	3	6	12	24	48	96
Adjusting Cardiac Monitor/Connecting Leads/ Reset Alarm	1	2	4	8	15	30

	1	2	3	6	9	12
Abdominal Girth Measurement.	1	1	2	4	6	8
Extremity Circumference Measurement . . . . .	.5	.5	1	2	2	3
Monitor Leads Application/Exchange.	1	1	2	4	6	
Cardiac Output Measurement	2	4	6	12		

	1	2	3	4	5	6
Heart Sounds Assessment . . . . .	.5	1	1	2	2	3
12 Lead ECG	3	7	10	14	17	21
Bed Scale Weight.	2	4	6			
Ambulatory Weight . . . . .	.5	1				

	3	6	9	12	18	24
Mental Alertness.	1	2	3	4	5	7
Orientation	1	2	3	4	6	8
Pupil Reflexes. . . . .	.5	1	2	3	4	5
Motor/Sensory Testing	1	2	4	5	7	9
Pulmonary Assessment.	2	3	5	6	10	13
Bowel Sound Assessment.	2	3	5	6		

	3	6	9	12	18	24
Urine Testing - Protein . . . . .	.5	1	2	3	4	5
Urine Testing - Specific Gravity.	1	2	3	3	5	7
Urine Testing - Sugar & Acetone	2	4	5	7	11	14
Guaiac Testing - Feces/Vomit/GI Drainage.	1	2	3	4	6	9

	1	2	3	4	6	9
Hematocrit.	1	3	4	5	8	11
Situational Observation	9	19	28			

PCIS .
29-31 32

PSYCHOLOGICAL/PATIENT TEACHING

	FREQUENCY	1	2	3	6	12	24
Answering Patient's Question	SCORE	.5	1	1	2	4	8
Orientation to Clinical Unit		2	3	5			
Visiting with Patient/Purposeful Interaction		3	6	9	12	24	48
Explanation of Procedures/Tests.		2	4	6	8	17	34
		2	3	5	7	14	28
Teaching - Diagnostic Test		1	2	3	4	5	6
Teaching - Dietary Explanation . . . . .		.5	1	1	1	2	2
Teaching - Blow Bottles/Incentive Spirometer		1	2	3	4	5	6
Teaching - Medication Administration		1	2	4	5	6	7
		7					
Teaching - Disease/Condition Related		1	2	3	6	9	12
		2	4	6	12	18	25

PCIS .
 .33-35 36

GASTROINTESTINAL

	FREQUENCY	1	3	6	9	12	24
Nasogastric Tube - Instillation.	SCORE	1	2	5	7	10	19
Nasogastric Tube - Irrigation. . . . .		.5	2	3	5	6	13
Nasogastric Tube - Insertion		1	2	3	4	5	6
Nasogastric Tube - Removal		3	5	8	11	13	16
		.5	1				
Rectal Tube Insertion/Removal OR Fecal		1	2	3			
Impaction Assessment/Removal		1	2	3			
Dressing Change - Colostomy/Ileostomy/ Ileocolect.		1	2	3	4	5	6
		3	5	8	11	14	16

PCIS .
 37-39 40

RESPIRATORY

	FREQUENCY	3	6	9	12	24	48
Oxygen Administration	SCORE	1	2	3	4	8	17
Suctioning - Oral		3	6	9	12	18	24
Suctioning - Endotracheal/Tracheostomy/ Naso-Tracheal		2	3	5	7	10	13
Cough and Deep Breathe.		3	7	10	14	20	27
Chest Pulmonary Therapy - Frappage with Postural Drainage		2	5	7	9	14	18
Tracheostomy - Cleaning Cannula/Dressing Change		4	7	11	15	22	29
Blow Bottles/Incentive Spirometer		6	12	19	25		
IPPB Treatment		3	6	10	13		
		8	16	24	32		
Positioning for X-Ray		1	2	3	4	5	6
Chest Tube - Care		1	3	4	5	6	8
Chest Tube - Changing Bottles		4	8	11	15		
Chest Tube - Insertion.		3	6	9			
Chest Tube - Removal.		9	18				
Intubation.		2	4				
Extubation.		6	12				
		1					

PCIS .
 41-43 44

CARDIOVASCULAR/TEMPERATURE REGULATION

	FREQUENCY	1	2	3	6	9	12
	SCORE						
Venipuncture - Blood Sample		1	2	4	7	11	14
Venipuncture - Blood Culture		2	3	5			
		3	6	9	12	18	24
Arterial Puncture - Blood Gases		5	11	16	22	33	44
Intravenous/Arterial Line - Blood Sample		3	6	9	12	18	23
IV Infusion - Changing IV Bottle		2	3	5	7	10	13
		1	2	3	6	9	12
IV Infusion - Initiating/IV Catheter Care. .		3	6	10	19	29	38
		1	3	6	12	18	24
IV Infusion - Infusion Pump Setup/IV or		1	3	7	14	21	28
Arterial Line Termination.							
		1	3	6	12	24	48
IV Infusion - IV Push Medication/		5	2	4	8	15	30
Piggy-Back Medication.		1	3	7	13	27	53
IV Infusion - Platelets/Plasma/Blood							
		12	24	48	96	120	144
IV Infusion - Flow Rate.		3	6	12	24	30	36
		1	2	3			
Arterial Line - Transducer Exchange.		5	11	16			
Arterial Line - Setup.		6	11				
Arterial Line - Initiation		14	28				
Arterial Line - Swan Ganz Catheter Setup . .		11	22				
Swan Ganz Catheter - Initiation.		14	27				
Swan Ganz Catheter - Removal		2					
		1	2	3	4	5	6
Elastic Stockings/Ace Bandage.		1	2	3	5	6	7
Cardiopulmonary Resuscitation.		21	42	62	83	104	124
Hypothermia/Hyperthermia Treatment		2	4				
Cardioversion.		8	15				
External Pacemaker		3	7				

PCIS .
45-47 48

SKIN

	FREQUENCY	1	2	3	6	9	12
	SCORE						
Small Dressing Change (<4" x 8")/ Suture or Skin Clip Removal (<15).		2	4	6	13	19	25
Large Dressing Change (≥ 4" x 8")/Wound							
Irrigation/Local Surgical Prep		4	8	11	23	34	45
Reinforcing Dressing		1	2	4	7	11	14
Hot Compress / Wound Culture.		1	2	3	5	8	10
Decubitus Care/Cold Compress		3	5	8	16	24	32
Application of K-Pad/Heat Lamp		5	1	1	3	4	5
Suture or Skin Clip Removal (≥15).		5	10	14			
Air Floatation/Alternating Pressure Mattress		2					
		6	12	24	48	72	96
Isolation, Gowning & Gloving		3	6	12	23	35	47

PCIS .
49-51 52

SKELETAL/NEUROLOGICAL/EENT

	FREQUENCY	1	2	3	4	5	6
	SCORE	2	5	7	9	11	14
Pin/Head Tongs Care.							
Extremity Traction - Application	1	2	3	6	9	12	
Extremity Traction - Adjust.	1	2	3	5	8	10	
Extremity Elevation.	1	3	6	9	12	24	
Cast Care. . . . .	.5	1	2	3	4	7	
Ice Pack . . . . .	.5	1	2	3	4	9	
Eye Care . . . . .	.5	1	2	2	3	6	
Instillation of Drops - Eye/Ear/Nose . . . . .	.5	2	4	5	7	14	
	.5	.5	1	2	2	5	
Culture - Sputum	1	2	3				
Culture - Nose/Throat.	1	2	2				
	.5	.5					
Circulation Check.	6	12	24	48	96	120	
	1	3	5	11	21	27	

PCIS .
53-55 56

UROLOGICAL/GYNECOLOGICAL

	FREQUENCY	1	2	3	6	9	12
	SCORE						
Foley Catheter Care/Foley Catheter Removal/Condom Catheter Application/Bladder Irrigation		1	2	4	7	11	15
Perineal Care.	1	2	2	5	7	10	
Changing Perineal Pad. . . . .	.5	.5	1	2	2	3	
Urine Specimen - Clean Catch/Foley Catheter.	1	2	3	4	5	6	
Urine Specimen - Routine . . . . .	.5	1	2				
Catheterization - Foley.	3	5					

PCIS .
57-59 60

Locate required nursing activity on the Critical Care Nursing Activities Tasking Document and calculate total points based on the weighted score provided. (Specify activity(s) and Total Score(s)).

THERAPEUTIC ACTIVITIES/MODALITIES (OTHER)

Nursing Activity	Frequency Rate	X	Score	=	Sub-Total
_____	_____		_____		_____
_____	_____		_____		_____
_____	_____		_____		_____

PCIS .
61-63 64

APPENDIX C

Critical Care Patient Classification Instrument Instructional Information

CRITICAL CARE PATIENT CLASSIFICATION INSTRUMENT

INSTRUCTIONAL INFORMATION

1. Demographic Information:

a. Stamp the Critical Care Patient Classification Instrument with the patient's Hospital Card in the space provided.

b. Record the date of the data collection period. Note that the rater completed this form at the end of the 24-hour period.

c. Record the rater's name in the appropriate blank.

d. Utilize the keypunch spaces 1 through 12 to collect data which best meets the requirements for your medical treatment facility. This demographic data could include the following:

- (1) Age of Patient
- (2) Sex of Patient
- (3) Day of the Week
- (4) SI or VSI Status
- (5) Clinical Service

2. The Critical Care Patient Classification Instrument is an objective factor evaluation designed rating instrument. Extensive clinical observation combined with time and frequency studies were undertaken to identify those direct nursing care activities which most influence the total patient care requirements. These groupings of nursing activities, listed below, are considered to be Patient Care Indicators. Each nursing activity is operationally defined in the attached Tasking Document. The sum of the total points within each patient care indicator will become the Patient Care Indicator Score (PCIS).

- a. Hygiene
- b. Nutrition/Elimination
- c. Mobility/Exercise/Safety
- d. Medication
- e. Vital Signs/Assessment/Diagnostic Tests
- f. Psychological/Patient Teaching
- g. Gastrointestinal
- h. Respiratory

4. The actual rating of each patient is accomplished by selecting the frequency rate for each nursing activity that was required during the rating period. The rating of the patient on the classification instrument is then accomplished by selecting the frequency rate from the options provided on the instrument. Select the frequency rate for each nursing activity that best meets the care requirements for the patient being rated. Each frequency rate has a corresponding point value (weighted score) as denoted in the blocks below each frequency rate.

	1	3	6	9	12	24
Oral Hygiene	1	3	6	10	13	26

EXAMPLE:

This Patient Care Indicator (Medication) consists of "3" Oral, "6" Topical, and "1" Intramuscular for a total of "3.5" points.

5. If the patient requires a nursing activity that is not included on the Critical Care Patient Classification Instrument, this additional procedure should be followed:

Locate the Nursing Activity Tasking Document (pages 19 thru 23) and obtain the score (points) for that activity. This point value is for a frequency of one, therefore, you must then multiply that figure by the appropriate frequency rate.

EXAMPLE:

UROLOGICAL

URINARY BLADDER TRAINING: Upon arrival at bedside, clamp/unclamp catheter, record time and urine output if appropriate. .5

Should the patient require eight urinary bladder training procedures during the 24-hour period, multiply the frequency of "8" times the score of ".5". Indicate the activity(s) selected and the total point value clearly on the instrument (i.e., Urinary Bladder training = 4).

6. The total PCIS points (Sum of the Patient Care Indicator Scores) determines the patient's Category of Care. Indicate the Total PCIS Points and circle the appropriate Category on page 1 of the Critical Care Patient Classification Instrument.

EXAMPLE:

TOTAL PCIS.Points	WEIGHTED SCORE (Points)	CATEGORY (Circle One)
	>40 - 79	2
	80 - 159	3
	160 - 239	4
	240 - 499	5
	500 - 720	6
159.5		

ROUND DOWN THE FRACTIONS: For Example, 159.5 is less than "160" TOTAL PCIS Points will have the WEIGHTED SCORE of "159" and will remain Category "3".

7. The Critical Care Patient Classification-Tabulation Form was developed for the recording of the Patient Care Indicator Scores (PCISs). These scores are to be recorded on this tabulation form along with the patient's name and age.

CRITICAL CARE PATIENT CLASSIFICATION TABULATION FORM

TOTAL POINTS	HOURS OF CARE	CATEGORY OF CARE	NO. OF CASES
>40 - 79	2 - 3	2	
80 - 159	4 - 7	3	
160 - 239	8 - 11	4	
240 - 499	12 - 24	5	
500 - 720	25 - 36+	6	

Nursing Unit			Patient Care Indicator Scores														Total PCIS Score	Category of Care
Bed No.	Age	Name of Patient	Hygiene	Nutrition/ Elimination	Mobility/ Exercise/Safety	Medication	Vital Signs/ Assessment/ Diagnostic Tests	Psychological/ Patient Teaching	Gastrointestinal	Respiratory	Cardiovascular/ Temperature Regulation	Skin	Skeletal/ Neurological/ENT	Urological/ Gynecological	Other/Therapeutic Activities/ Modifications			

CRITICAL CARE NURSING ACTIVITIES TASKING DOCUMENT

Each operational procedure includes: (1) Identify and screen the patient; (2) Explain the procedure to the patient; (3) Raise, lower, or adjust the bed before and after the nursing activity; and (4) Clean and straighten area.

HYGIENE:

SCORE

BATHING, COMPLETE: Place equipment at bedside; remove pajamas, bathe face, chest, abdomen and extremities; change water, bathe back, buttocks and perineal area; replace pajamas; and remove equipment from area. 7

BATHING, ASSIST WITH BACK AND LEGS: Place equipment at bedside; remove pajamas, allow for patient bathing as if in attendance; change water; then bathe back and lower extremities; replace pajamas and remove equipment from area. 4

AM CARE: Place equipment at bedside, assist patient with bathing face, hands, and brushing teeth; then remove equipment from area. 2

AM CARE, PARTIAL: Place equipment at bedside, prepare bath water, put toothpaste on toothbrush; and remove equipment from area when patient has completed AM Care (observer will be in attendance during the nursing activity.) 1

ORAL HYGIENE: Place equipment at bedside, turn patient to his/her side, cleanse gums, teeth and mouth with applicators; then remove equipment from area. 1

SKIN CARE: Place equipment at bedside, cleanse and dry areas for special care, apply lotion, and then remove equipment from area. (Buttocks, hips, shoulders, heels.) 1

OR

BACK RUB: Place equipment at patient's bedside, remove pajama top, turn patient to expose back, rub back with lotion, replace pajama top, and then remove equipment from area.

PM CARE: Place equipment at bedside; bathe face and hands, brush teeth, and rub back; tighten and straighten bed linens; then remove equipment from area. 4

SHAVING: Place equipment at bedside; wet and lather face/or use an electric razor and shave face; then remove equipment from area. 2

OCCUPIED BED: Place linen at bedside; turn patient on side, roll linen to one side of bed, replace with clean linen, turn patient to freshly made side of bed, remove soiled linen and complete bed making; then remove soiled linen from bed. 3

UNOCCUPIED BED: Place linen at bedside, remove soiled linen, place bottom sheet on mattress, then place on top sheet; change pillow cases; remove soiled linen from area. 2

SCORE

CHANGING BED LINEN PROTECTOR/CHUX: Upon arrival at bedside, position patient, remove soiled chux, place clean chux under patient, straighten bed; then remove used chux from area. .5

NUTRITION/ELIMINATION:

FLUID: Place fluids at bedside, place plastic drinking tube in liquid, give liquid to patient, then remove drinking cup and/or place within reach at patient's bedside. .5

OR

SNACK: Place snack at bedside and, if required, prepare food for eating.

FEEDING: Place meal tray at bedside; place towel or napkin as bib; prepare the food, feed patient slowly with appropriate utensils; then remove tray from area. 5

SERVING MEAL TRAY, PREPARATION REQUIRED: Place tray at bedside, prepare food and utensils, and prepare towel or napkin as bib.

SPECIAL FEEDING - HYPERALIMENTATION: Determine calibration of infusion equipment. Place hyperalimentation fluids at bedside, exchange filter and tubing, establish scheduled flow rate, record, and then remove equipment from area. 2

SPECIAL FEEDING - NASOGASTRIC: Place feeding at bedside, unclamp tube, assess placement of tube, administer tube feeding, flush tube with water, clamp tube, record, and then remove feeding equipment from area. 1

OR

SPECIAL FEEDING - NASOGASTRIC, CONTINUOUS FEEDING WITH GASTRIC FEEDING EQUIPMENT: Place equipment at bedside; connect to feeding tube/nasogastric tube, adjust flow rate, record on Intake and Output record; then remove equipment from area.

OR

SPECIAL FEEDING - NASOGASTRIC, CONTINUOUS WITH INFUSION PUMP: Place equipment at bedside; remove and/or position feeding bottle, connect to feeding tube, set up through flow rate adjuster of equipment, establish flow rate, record on Intake and Output record; then remove equipment from area.

OR

SPECIAL FEEDING - GASTROSTOMY: Place feeding at bedside, uncoil and unclamp tube, administer feeding, flush tube with water, clamp tube, recoil and replace tube, and then remove feeding equipment from area.

MEASURING & RECORDING INTAKE: Place calibrated cylinder/container at bedside; measure or calculate fluids and record amount on Intake and Output record; then remove used equipment from area. .5

MEASURING & RECORDING OUTPUT - URINE: Place calibrated cylinder at bedside; measure or calculate volume, record amount on Intake and Output record; then remove equipment from area. .5

SCORE

OR

MEASURING & RECORDING OUTPUT - LIQUID FECES: Remove bedpan from patient's bedside; measure feces in calibrated cylinder, record amount on Intake and Output record. .5

OR

MEASURING & RECORDING OUTPUT - VOMITUS: Remove emesis from patient's bedside, measure vomitus in calibrated cylinder, record amount on Intake and Output record.

OR

OUTPUT WEIGHT - DIAPER/BED LINENS: Upon the completion of the procedure for diaper change/bed linen change, remove items to be weighed, weigh on weight scales, and then record results.

MEASURING & RECORDING OUTPUT - DRAINAGE BOTTLES/ALL TYPES: Place calibrated cylinder at bedside, pour contents from drainage bottle into calibrated cylinder, measure or calculate volume, replace drainage bottle, record amount on Intake and Output record, and then remove equipment from area. .5

GIVING A BEDPAN: Place bedpan at bedside, place patient on bedpan, provide toilet tissue, remove patient from bedpan, cover bedpan, and remove from area. 1

GIVING A URINAL: Place urinal at patient's bedside, remove cover, adjust patient's pajamas for placement of urinal, remove urinal from patient, replace cover; then remove urinal from area. .5

INCONTINENT CARE: Place equipment at patient's bedside, bathe buttocks, 2 perineum and thighs; change bedding; then remove equipment and soiled linen from area.

MOBILITY/EXERCISE/SAFETY:

CHANGING PATIENT'S POSITION IN BED: Remove support pillows, reposition patient; apply support pillows. .5

ADJUSTING POSITION OF BED: Raise, lower or adjust position of bed. .5

OR

FOWLERS/TRENDELENBERG POSITION: Upon arrival at bedside, position bed in either Fowlers or Trendelenberg position, assess comfort of patient in this position, and then depart from area.

ADJUSTING SIDERAIL: Changing position of siderails, i.e., up, down or removal. .5

ADJUSTING RESTRAINT: Upon arrival at bedside, replace or apply restraints to upper and/or lower extremities, and then depart from area. .5

EXERCISE - ACTIVE: Supervise the patient as he/she actively performs the prescribed exercise program. 2

SCORE

OR

EXERCISE - PASSIVE: Manually move patient's extremities through the prescribed exercise program. 2

MOBILITY - BED TO STRETCHER: Place stretcher at bedside, transfer patient to stretcher, fasten safety straps or adjust siderail, remove stretcher from bedside (or reverse procedure). 2

OR

MOBILITY - BED TO CHAIR: Position chair/wheelchair at bedside, assist patient into sitting position, slowly bring patient into an upright standing position; then assist into chair/or reverse process.

OR

MOBILITY - AMBULATING FIRST TIME: Assist patient into sitting position on side of bed; then into upright standing position; walk with patient; then assist patient back into bed.

MOBILITY - ASSISTANCE WHILE WALKING: Assist patient into a sitting position on side of bed, then into an upright standing position, then with ambulation, and then back into bed. 1

OR

MOBILITY - BED TO COMMUNE: Position commode chair next to bedside, assist patient into sitting position, slowly bring patient into an upright standing position, assist patient onto commode chair, and then assist patient back into bed.

MOBILITY - BED TO FLOOR: Assist patient into sitting position on side of bed, then slowly bring patient into an upright standing position; then assist back into bed. .5

OR

MOBILITY - SITTING ON SIDE OF BED: Assist patient into sitting position on side of bed; then assist patient back into supine position.

TURNING FRAMES, ALL TYPES: Remove or secure support pillows and devices, place and secure restraining straps, unlock frame, turn frame according to specifications, lock frame, remove restraining straps, adjust pillows and support devices. 3

MEDICATION:

ORAL: Upon arrival at bedside, obtain a glass of water and administer the oral medication. .5

TOPICAL: Place equipment at bedside, locate and expose site for topical application of medication, apply medication, and then remove equipment from area. .5

INTRAMUSCULAR: Place equipment at bedside, locate site for injection, administer medication, and then remove equipment from area. .5

SCORE

SUBCUTANEOUS: Place equipment at bedside, locate site for injection, administer medication, and then remove equipment from area. .5

SUBLINGUAL: Place equipment at bedside, place medication under patient's tongue; then remove equipment from area. .5

SUPPOSITORY, RECTAL/VAGINAL: Place equipment at bedside, prepare and administer suppository; then remove equipment from area. .5

VITAL SIGNS/ASSESSMENT/DIAGNOSTIC TESTS:

BLOOD PRESSURE, MANUAL: Place equipment at bedside, place cuff around extremity, position stet. scope, measure blood pressure, remove cuff, record results; remove equipment from area. .5

PULSE - RADIAL/BRACHIAL: Place fingers over radial pulse or brachial pulse, and count rate. Remove fingers from pulse area and record results. .5

OR

PULSE - PEDAL/FEMORAL/POPITEAL: Place fingers on the dorsalis pedis artery pulse and count rate. Remove fingers from pulse area and record results.

PULSE - APICAL: Place equipment at bedside, place stethoscope over apex of heart and count rate, remove stethoscope, record pulse rate, and then remove equipment from area. .5

RESPIRATIONS: Count respiratory rate, and/or count and calculate rate, and then record. .5

ORAL TEMPERATURE, PULSE & RESPIRATIONS: Place equipment at bedside, position temperature probe or thermometer. Place fingers over radial artery pulse and count rate. Count respiratory rate while fingers are placed over radial artery pulse. Remove fingers from radial artery pulse rate, record results of measurements, and then remove equipment from area. .5

TEMPERATURE - ORAL, ELECTRONIC/MERCURY: Place equipment at bedside, place probe or thermometer under tongue, measure temperature, remove temperature probe or thermometer, record and then remove equipment from area. .5

OR

TEMPERATURE - RECTAL, ELECTRONIC/MERCURY: Place equipment at bedside, adjust clothing, insert temperature probe or thermometer in anus, measure temperature, remove temperature probe or thermometer, record, and then remove equipment from area.

OR

TEMPERATURE - AXILLARY, ELECTRONIC/MERCURY: Place equipment at bedside, place temperature probe or thermometer in axillary area, measure temperature, remove temperature probe or thermometer, record and then remove equipment from area.

	<u>SCORE</u>
<u>RHYTHM STRIP - MONITOR</u> : Obtain 20 second strip, record name, date and time, then file for future use.	.5
<u>RHYTHM STRIP MEASUREMENTS</u> : Upon obtaining the rhythm strip, measure P-R interval, S-T segment, and assess for arrhythmic pattern; then record results.	.5
<u>RHYTHM STRIP - ECG MACHINE</u> : Place equipment at bedside, prepare equipment for use, apply limb leads, obtain 20 second strip, record name, date and time, remove limb leads; then remove equipment from area.	3
<u>PULMONARY ARTERY PRESSURE WEDGE</u> : Upon arrival at bedside, flush line, slowly inject air into Swan-Ganz Catheter, assess and calculate wedge pressure, and record the results.	.5
<u>CENTRAL VENOUS PRESSURE</u> : Set up equipment for measurement of pressure, position patient and assess sternal angle, measure pressure, restore equipment to original position, and record results.	.5
<u>MONITOR READING - BLOOD PRESSURE/HEART RATE - RHYTHM/PULMONARY ARTERY PRESSURE/CENTRAL VENOUS PRESSURE</u> : Upon arrival at bedside, assess and record findings.	.5
<u>ADJUSTING CARDIAC MONITOR/CONNECTING LEADS/RESET ALARM</u> : Upon arrival at bedside, adjust cardiac monitor, connect leads or reset the alarm; then depart the area.	.5
<u>ABDOMINAL GIRTH MEASUREMENT</u> : Upon arrival at bedside, expose abdominal area, measure girth, record and then depart the area.	1
<u>EXTREMITY CIRCUMFERENCE MEASUREMENT</u> : Upon arrival at bedside, place tape measure around the extremity/extremities and assess measurement; then record results.	.5
<u>MONITOR LEADS APPLICATION</u> : Place equipment at bedside, exchange leads/ or apply new leads, and then remove equipment from area.	1
<u>CARDIAC OUTPUT MEASUREMENT</u> : Place equipment at bedside, assist physician with measurement, then remove equipment from area.	2
<u>HEART SOUNDS ASSESSMENT</u> : Place stethoscope at bedside, arrange pajamas for visual access of chest, assess and record findings; remove stethoscope from area.	.5
<u>12 LEAD ECG</u> : Place equipment at bedside, connect leads to patient and obtain ECG. Record name, date and time on ECG. Remove leads and clean skin, then remove equipment from area.	3
<u>BED SCALE WEIGHT</u> : Place equipment at bedside, assist patient onto the scales, read and record weight reading, assist patient in getting off the scales, and then remove equipment from area.	2

SCORE

AMBULATORY WEIGHT: Place equipment at bedside, assist patient onto the scales, balance scales, read and record weight reading, assist patient off the scales, and then remove equipment from area. .5

MENTAL ALERTNESS: Upon arrival at bedside, make inquiries within the framework of interviewing that will give information about the patient's orientation, memory, intellectual performance, and judgment; then record results. .5

ORIENTATION: Upon arrival at bedside, make inquiries within the framework of interviewing that will give information about the patient's orientation for time, place and person, and then record results. .5

PUPIL REFLEXES: Place equipment at bedside, adjust room lighting, assess pupillary reflexes with flashlight and remove equipment from area. .5

MOTOR/SENSORY TESTING: Upon arrival at bedside, assess extremities for sensation awareness and muscle strength. .5

PULMONARY ASSESSMENT: Upon arrival initiate assessment by auscultation of the lungs and/or percussion of the chest wall over the involved areas. Assess symmetry of chest and determine if respiratory movement is abdominal or thoracic. .5

BOWEL SOUND ASSESSMENT: Upon arrival at bedside, utilize a stethoscope to assess status of bowel sounds, then remove equipment from area. .5

URINE TESTING - PROTEIN: Upon arrival at bedside, collect urine sample, utilizing test strip for albumin, compare test strip against standard, read and record results; then remove used equipment from area. .5

URINE TESTING - SPECIFIC GRAVITY: Place equipment at bedside, collect urine sample and utilizing a urometer, measure specific gravity, record results, and then remove equipment from area. .5

URINE TESTING - SUGAR & ACETONE: Place equipment at bedside, collect urine sample, measure sugar and acetone, record results, then remove equipment from area. .5

GUAIAK TESTING - FECES/VOMITUS/GI DRAINAGE: Upon obtaining sample, test sample for guaiac, record results, and then remove from area. .5

HEMATOCRIT: Upon obtaining the blood sample, process, assess and record the results. 1

SITUATIONAL OBSERVATION: Assignment of one member of the nursing team to observe and provide nursing care to the patient during a specific activity. Observation required only during the specific activity. This might include, but is not limited to, transport within or without the hospital when the patient is not stable enough to be left without nursing support. 9

PSYCHOLOGICAL/PATIENT TEACHING:

ANSWERING PATIENT'S QUESTION: Time spent in answering patient's questions or in response to the patient call system. .5

SCORE

<u>ORIENTATION TO CLINICAL UNIT:</u> Instruct on the use of the nurse's call system, the hospital bed, and the layout of the physical facility.	2
<u>VISITING WITH PATIENT/PURPOSEFUL INTERACTION:</u> Time spent at patient's bedside without providing any direct physical care to patient which is not in response to patient call system or patient questions.	.5
<u>EXPLANATION OF PROCEDURES AND TESTS:</u> Instruct patient on what he/she can expect from procedure/test, what the health care personnel will be doing during the procedure/test, and why such procedure/test is being done.	.5
<u>TEACHING - DIAGNOSTIC TEST:</u> Upon arrival at bedside, provide information on the purpose and requirements for the diagnostic tests.	.5
<u>TEACHING - DIETARY EXPLANATION:</u> Upon arrival at bedside, provide information on dietary requirements/restrictions.	1
<u>TEACHING - BLOW BOTTLES/INCENTIVE SPIROMETER:</u> Place equipment at bedside, instruct patient on the purpose and use of equipment.	1
<u>TEACHING - MEDICATION ADMINISTRATION:</u> Upon arrival at bedside, provide instruction on dosage, route, and specific drug related information.	7
<u>TEACHING - DISEASE/CONDITION RELATED:</u> Upon arrival at bedside, provide instruction on the nature and scope of the disease process, special care requirements, limitations and/or restrictions related to disease illness.	2

GASTROINTESTINAL:

<u>NASOGASTRIC TUBE - INSTILLATION:</u> Place medication and/or normal saline at bedside, unclamp or disconnect tube, instill solution with asepto syringe, reclamp or reconnect tubing; then remove equipment from area.	1
<u>NASOGASTRIC TUBE - IRRIGATION:</u> Place irrigation solution at bedside, unclamp or disconnect tube, irrigate with asepto syringe, reclamp or reconnect tubing; then remove equipment from area.	.5
<u>NASOGASTRIC TUBE - INSERTION:</u> Place equipment at bedside, secure towel around patient's neck, give patient glass of water, instruct patient on how to swallow tube, lubricate tube, insert tube, assess for placement, tape in position, then remove equipment from area/or when non-responsive omit glass of water and instructions.	3
<u>NASOGASTRIC TUBE - REMOVAL:</u> Place towel around patient's neck, position patient, remove tape, clamp tube and remove tubing, and then remove equipment from area.	.5
<u>RECTAL TUBE - INSERTION:</u> Place equipment at bedside, insert rectal tube, connect ot drainage bag; then remove used equipment from area.	1
OR	
<u>RECTAL TUBE - REMOVAL:</u> Place equipment at bedside, remove rectal tube and drainage bag; then remove used equipment from area.	

OR

FECAL IMPACTION - ASSESSMENT/REMOVAL: Upon arrival at bedside, position 1 patient, put on rubber gloves, assess for fecal impaction and then manually break up fecal mass; then remove used equipment from area.

DRESSING CHANGE - COLOSTOMY: Place equipment at bedside, remove soiled 3 dressing, cleanse skin and stoma, apply clean dressing, and then remove equipment from area.

OR

DRESSING CHANGE - ILEOSTOMY/ILEOCONDUIT: Place equipment at bedside, remove ileostomy bag or dressing, cleanse skin and stoma area, replace ileostomy bag or dressing, and remove equipment from area.

RESPIRATORY:

OXYGEN ADMINISTRATION - RESPIRATOR: Upon arrival at bedside assess .5 and/or regulate oxygen and ventilator pressures, assess all tubing for patency and collection of fluids within tubing, assess fluid level in water vapor container, and then assess proper position of alarms.

OR

OXYGEN ADMINISTRATION - PRONGS: Place equipment at bedside, fit nasal prongs and adjust headband, regulate oxygen rate; evaluate patient's adjustment to oxygen and equipment.

OR

OXYGEN ADMINISTRATION - MASK: Place equipment at bedside, turn on oxygen, fit the mask over the mouth and nose, adjust headband, evaluate fit and patient's adjustment to the equipment, and regulate oxygen flow rate.

OR

OXYGEN ADMINISTRATION - NASAL: Place equipment at bedside, turn on oxygen, lubricate and insert nasal catheter, secure with tape; evaluate and regulate oxygen flow rate.

OR

OXYGEN ADMINISTRATION - MIST WITH COLLAR/FACE TENT: Place equipment at bedside, turn on oxygen, position equipment; then secure, evaluate and regulate oxygen flow rate.

SUCTIONING - ORAL: Place equipment or set up equipment at bedside, suction oral cavity with suction catheter/or oral suction tip, flush catheter before and after each aspiration, replace used equipment, and remove used equipment from area. .5

SUCTIONING - ENDOTRACHEAL: Set up sterile equipment at bedside, put on 1 sterile gloves, suction through endotracheal tube, flush catheter before and after each use, bag breathe between each aspiration, remove gloves, replace used equipment, and then remove used equipment from area.

OR

SUCTIONING - TRACHEOSTOMY: Set up equipment, put on sterile gloves, suction and flush catheter before and after each aspiration, replace used equipment, and remove used equipment from area.

OR

SUCTIONING - NASO-TRACHEAL: Set up equipment at bedside, put on sterile gloves, pass nasal catheter and suction, flush catheter before and after each aspiration, replace used equipment; remove used equipment from area.

SCORE

COUGH AND DEEP BREATHE: Upon arrival at bedside, have patient cough and .5 deep breathe, if cough productive then dispose of sputum.

CHEST PULMONARY THERAPY - FRAPPAGE WITH POSTURAL DRAINAGE: Upon arrival 1 at bedside, position patient, initiate treatment by auscultation of lung fields. Perform percussion to each involved segment followed by vibration.

TRACHEOSTOMY - CLEANING CANNULA: Place or utilize equipment at bedside, 2 complete tracheostomy suction, remove, clean and replace inner tube, and then remove soiled equipment and replace with clean equipment.

OR

TRACHEOSTOMY - DRESSING CHANGE: Place equipment at bedside, remove soiled dressing, cleanse skin, replace dry dressing, change tracheostomy ties as indicated, and then remove soiled equipment from area.

BLOW BOTTLES: Place equipment at bedside, assist with placement of bottles, have patient perform procedure; then locate equipment at bedside for next treatment.

OR

INCENTIVE SPIROMETER: Place spirometer at bedside, assist patient during the procedure to determine proper usage of spirometer, and then remove or replace at storage area at bedside.

IPPB TREATMENT: Place equipment in position of use, assist patient 3 during the treatment, and replace equipment after use.

POSITIONING FOR X-RAY: Upon arrival at bedside, assist with positioning 1 of x-ray film; then assist with removal of exposed film.

CHEST TUBE CARE: Set up equipment at bedside, remove dressing around 4 chest tube, cleanse skin, replace dressing, tape securely, and then remove used equipment from area.

CHEST TUBE - CHANGING BOTTLES: Place prepared chest tube bottles at 3 bedside, clamp chest tube, change drainage tube and bottles, secure drainage bottles and tops with tape, unclamp chest tube, and then remove used equipment from area.

CHEST TUBE - INSERTION: Place all equipment at bedside, assist physician 10 with insertion of chest tube, prepare water-sealed drainage bottles, tape all connections and drainage bottles; remove equipment from area.

CHEST TUBE - REMOVAL: Place equipment at bedside, assist physician 2 with removal of chest tube, apply pressure dressing; then remove equipment from area.

INTUBATION: Place equipment at bedside, assist physician during the 6 intubation process, tape endotracheal tube in place and remove equipment from area.

EXTUBATION: Place equipment at bedside, assist physician with removal 1 of endotracheal tube; then remove equipment from area.

CARDIOVASCULAR/TEMPERATURE REGULATION:

SCORE

- VENIPUNCTURE - BLOOD SAMPLE: Place equipment at bedside. Apply 1
tourniquet to extremity, cleanse site, perform venipuncture and with-
draw blood sample, and then apply pressure to puncture site. Apply
labels on blood tubes and remove equipment from area.
- VENIPUNCTURE - BLOOD CULTURE: Place equipment at bedside, apply tour- 2
niquet to extremity, clean site, perform venipuncture and withdraw
blood sample, and then apply pressure to puncture site. Apply labels
on blood culture bottle and remove equipment from area.
- ARTERIAL PUNCTURE - BLOOD GASES: Place equipment at bedside, locate 2
arterial puncture site, perform puncture and draw blood, and then place
sample on ice. Apply pressure to puncture site; then label sample and
remove equipment from area.
- INTRAVENOUS/ARTERIAL LINE - BLOOD SAMPLE: Place equipment at bedside, 1
clear system, obtain blood sample through stopcock, flush system, label
samples, and then remove equipment from area.
- INTRAVENOUS INFUSION - CHANGING IV BOTTLE: Place equipment at bedside, .5
remove used IV container and replace with new IV container, calculate
and regulate flow rate, record on I&O record, and remove equipment from
area.
- INTRAVENOUS INFUSION - INITIATING: Place equipment at bedside, apply 3
tourniquet to extremity, cleanse site, perform venipuncture and connect
IV tubing, apply ointment and dressing, and tape securely. Calculate
and regulate flow rate, record on I&O record, and remove equipment from
area.
- OR
- INTRAVENOUS INFUSION - IV CATHETER CARE: Place equipment at bedside,
remove dressing from IV catheter site, cleanse skin, apply ointment,
replace dressing and then date, time and initial the dressing, change
IV tubing, and remove equipment from area.
- INTRAVENOUS INFUSION - INFUSION PUMP SETUP: Place equipment at bed- 1
side, set up IV tubing and adjust flow rate dial. Record on I&O
record and remove used equipment from area. (If existing IV container
present then remove and proceed as defined.)
- OR
- INTRAVENOUS/ARTERIAL LINE - TERMINATION: Place equipment at bedside,
remove dressing and terminate IV or arterial catheter/needle, apply
pressure to site, and record on I&O if appropriate. Remove equipment
from area.
- INTRAVENOUS INFUSION - IV PUSH MEDICATION: Place equipment at bedside, .5
select site for injection of solution utilizing existing system, ad-
minister IV solution, and remove equipment from area.
- OR
- INTRAVENOUS INFUSION - PIGGY-BACK MEDICATION: Place equipment at bed-
side, select site for administration of solution utilizing existing sys-
tems, record on I&O record, and remove equipment from area.

SCORE

- INTRAVENOUS INFUSION - PLATELETS/PLASMA: Place equipment at bedside, connect to present intravenous system, record on I&O record; and remove used equipment from area. 1
- OR
- INTRAVENOUS INFUSION - BLOOD: Place equipment at bedside, assure correct transfusion, etc., connect to present intravenous system, record on I&O record, and remove equipment from area.
- INTRAVENOUS INFUSION - FLOW RATE: Upon arrival at bedside, calculate and adjust flow rate as specified. .5
- ARTERIAL INFUSION - TRANSDUCER EXCHANGE: Place equipment at bedside, set up transducer tray and IV solution, calibrate the cardiac monitor, and measure the transducer current with a mercury sphygmomanometer. Remove equipment from area. 5
- ARTERIAL LINE - ARTERIAL LINE SETUP: Place equipment at bedside, set up transducer tray, IV solution and cardiac monitor. Assist physician with insertion of arterial catheter. Calibrate the cardiac monitor, and measure the transducer current with a mercury sphygmomanometer. Remove equipment from area. 6
- ARTERIAL LINE - INITIATION: Place equipment at bedside, assist physician with the procedure as required, connect to arterial line setup, assess status of arterial line; then remove equipment from area. 14
- ARTERIAL INFUSION - SWAN GANZ CATHETER SETUP: Place equipment at bedside, set up transducer tray, IV solution and cardiac monitor. Assist physician with the insertion of the Swan-Ganz catheter. Calibrate the cardiac monitor and then measure the transducer current with a mercury sphygmomanometer. Measure and record pulmonary artery pressure and/or PAEDP wedge. Remove equipment from area. 11
- SWAN GANZ CATHETER - INITIATION: Place equipment at bedside, assist physician with the procedure as required, connect to arterial line setup, assess status of arterial infusion system; then remove equipment from area. 19
- SWAN GANZ CATHETER - REMOVAL: Place equipment at bedside, assist physician with the removal of the Swan-Ganz catheter, apply dressing; then remove equipment from area. 2
- ELASTIC STOCKINGS: Place stockings at bedside. Expose lower extremities, and then put elastic stockings on lower extremities. 1
- OR
- ACE BANDAGE: Place equipment at bedside, wrap extremity securely with ace bandage and secure in place with tape or metal hooks.
- CARDIOPULMONARY RESUSCITATION: Upon arrival at bedside, perform any or all aspects of cardiopulmonary resuscitation. 21
- HYPOTHERMIA/HYPERTHERMIA TREATMENT: Place equipment at bedside, apply blankets, assess status of equipment. Insert rectal temperature probe for monitoring, and then remove unused equipment from area. 2

SCORE

CARDIOVERSION: Place equipment at bedside, assess vital signs (BP, P&R), assist physician with the procedure as required, repeat vital signs (BP, P&R); then remove equipment from area. 8

EXTERNAL PACEMAKER: Place equipment at bedside, assess vital signs (BP, P&R), assist physician with the procedure, repeat the vital signs (BP, P&R); then remove equipment from area. 3

SKIN:

SMALL DRESSING CHANGE, < 4"x 8": Place equipment at bedside, remove soiled dressing, cleanse skin, apply dressing to site, and then remove equipment from area. 2

OR

SUTURE/SKIN CLIP REMOVAL, < 15: Place equipment at bedside, remove dressing if required, remove sutures or skin clips, and then remove equipment from area.

LARGE DRESSING CHANGE, ≥ 4"x 8": Place equipment at bedside, remove soiled dressing, cleanse skin, apply dressing to site, and then remove equipment from area. 4

OR

WOUND IRRIGATION: Place equipment at bedside, remove soiled dressing, irrigate and cleanse site, apply dressing and then remove equipment from area.

OR

SURGICAL PREP, LOCAL: Place equipment at bedside, prepare skin for prep, shave area specified, and then remove used equipment from area.

REINFORCING DRESSING: Place equipment at bedside, apply dressing to present dressing for reinforcement, and then remove equipment from area. 1

HOT COMPRESS: Place equipment at bedside, apply hot compress to site, and then remove equipment from area. 1

OR

WOUND CULTURE: Place equipment at bedside, remove soiled dressing, obtain culture from site, label culture, apply new dressing, and then remove equipment from area.

DECUBITUS CARE: Place or position equipment at bedside, cleanse skin, apply heat lamp and/or expose to light. (If dressing is utilized, then count as dressing change.) 3

OR

COLD COMPRESS: Place equipment at bedside, apply cold compress to site and then remove equipment from area.

APPLICATION OF K-PAD: Upon arrival at bedside, apply K-pad to pre-scribed area, then depart from area. .5

SCORE

OR

HEAT LAMP: Place or position lamp at bedside, expose site, and apply heat lamp. .5

SUTURE/SKIN CLIP REMOVAL, > 15: Place equipment at bedside, remove dressing if required, remove sutures; remove equipment from area. 3

AIR FLOATATION/ALTERNATING PRESSURE MATTRESS: Place equipment at bedside, apply air floatation or alternating pressure mattress to hospital bed. (Turn patient as appropriate if application is made with patient in the bed.) Remove soiled linens/equipment from area. 2

ISOLATION, GOWNING & GLOVING: Upon arrival at isolation area, wash hands, put on isolation gown, mask and gloves, or when departing the isolation area, remove isolation gown, mask and gloves; then wash hands. .5

SKELETAL/NEUROLOGICAL/EENT:

PIN CARE: Place equipment at bedside, cleanse pin site; then remove used equipment from area. (Clean not sterile procedure.) 2

OR

HEAD TONGS CARE: Place equipment at bedside, cleanse area around head tongs, and then remove equipment from area.

EXTREMITY TRACTION - APPLICATION: Place equipment at bedside, apply non-invasive type traction to extremity, apply weights, and then remove unused equipment from area. 1

EXTREMITY TRACTION - ADJUST: Upon arrival at bedside, assess the position of the weights and the alignment of the traction equipment. 1

EXTREMITY ELEVATION: Place equipment at bedside, elevate extremity through use of pillows, bed adjustments and/or sling attachments. .5

CAST CARE: Upon arrival at bedside, assess for pain, swelling, numbness, tingling, coldness & bluish discoloration of the skin. Evaluate the patient's ability to move the part, and then assess the temperature of the cast and the skin area around the cast. .5

ICE PACK: Place ice bag at bedside, remove old ice bag and replace with new ice bag, secure ice bag in place; remove equipment from area. .5

EYE CARE: Place equipment at bedside, cleanse eyes and apply solution/ointment as prescribed. Apply eye patch and then remove equipment from area. .5

INSTILLATION OF DROPS - EYE: Upon arrival at bedside, position patient, instill eye drops, and then remove equipment from area. .5

OR

INSTILLATION OF DROPS - EAR: Upon arrival at bedside, position patient, instill ear drops, and then remove equipment from area.

OR

INSTILLATION OF DROPS - NOSE: Upon arrival at bedside, position patient, instill nose drops, and then remove equipment from area.

SCORE

CULTURE - SPUTUM: Place equipment at bedside, position patient, have patient cough to obtain sputum, apply label to sputum specimen, and then remove equipment from area. 1

CULTURE - NOSE: Place equipment at bedside, position patient, obtain nose culture, label culture, and remove equipment from area. .5

OR

CULTURE - THROAT: Place equipment at bedside, position patient, obtain culture, label culture, and remove equipment from area.

CIRCULATION CHECK: Upon arrival at bedside check extremity for swelling, numbness, and tingling, evaluate temperature and color of the skin, and then assess the patient's ability to move the part. .5

UROLOGICAL/GYNECOLOGICAL:

CATHETER CARE: Place equipment at bedside, cleanse area around catheter, apply ointment, and then remove used equipment from area. 1

OR

BLADDER IRRIGATION: Place equipment at bedside, set up equipment and irrigate bladder; then remove equipment from area.

OR

CONDOM CATHETER APPLICATION: Upon arrival at bedside, apply condom catheter, connect to a urinary drainage bag; then depart the area.

OR

FOLEY CATHETER REMOVAL: Place equipment at bedside, expose catheter and drainage system, deflate Foley balloon and remove Foley catheter. Measure urine and record on I&O record; then remove used equipment from area.

PERINEAL CARE: Place equipment at bedside, prepare and cleanse perineal area (use bedpan with treatment solution/or bathe area); then remove equipment from area. 1

CHANGING PERINEAL PAD: Place supplies at bedside, assess amount of bleeding, change perineal pads; then remove used supplies from area. .5

URINE SPECIMEN - CLEAN CATCH: Place equipment at bedside, instruct patient on how to collect specimen, label specimen, and then remove specimen from area. 1

URINE SPECIMEN - ROUTINE: Place equipment at bedside, instruct patient on how to collect specimen, label specimen, and then remove specimen from area. .5

CATHETERIZATION - FOLEY: Place equipment at bedside, prepare patient and insert Foley Catheter, inflate balloon, tape catheter in position, connect to urinary drainage bag; remove used equipment from area. 3

OTHER NURSING ACTIVITIES WHICH MAY BE UTILIZED TO DETERMINE CATEGORY OF CARE:HYGIENE:

- BATHING - UTENSILS PROVIDED: Place equipment at bedside, allow time for patient to bathe and change pajamas; then remove equipment from area. 1
- TUB BATH: Upon arrival in bathroom, assist patient in undressing, into bathtub, with bath and assist in redressing; then back into wheelchair (nursing personnel must be in constant attendance). 6
- SITTING SHOWER/SHOWER WITH ASSISTANCE: Upon arrival in the shower room, assist patient in undressing, into shower, with bath & hair shampoo, assist in redressing, and back into wheelchair. (Must remain with patient and provide assistance during the entire procedure.) 6
- AM CARE - UTENSILS PROVIDED: Place equipment at bedside, and then remove equipment from area when patient finishes AM Care. 1
- SHAMPOO: Place equipment at bedside; position patient, wet hair and apply shampoo, lather and rinse, dry hair with towel, comb and brush hair; and then remove equipment from area. 3
- NAIL CARE: Place equipment at bedside, wash hands/feet and nails, trim and clean finger/toenails, remove equipment from area. 1
- CHANGING TOP SHEET: Place linen at bedside, remove top sheet, replace with clean sheet; then remove soiled linen from area. .5
- CHANGING BOTTOM SHEET: Place linen at bedside, remove bottom sheet, replace with clean sheet, straighten top sheet; then remove soiled linen from area. 1

NUTRITION/ELIMINATION:

- SERVING MEAL TRAY, NO PREPARATION REQUIRED: Place tray at bedside. .5

VITAL SIGNS/ASSESSMENT/DIAGNOSTIC TESTS:

- PULSE - DOPPLER: Place equipment at bedside, place sensor over pulse area, assess and record pulse rate; then remove equipment from area (types of equipment may vary). 1
- PULMONARY ARTERY PRESSURE: Check placement of equipment, read, and record pressure readings. .5
- VITAL CAPACITY: Place equipment at bedside. Utilizing the spirometer determine the respiration reserve volume, the tidal volume and the expiratory reserve volume. Calculate and record results and then remove equipment from area. 2
- SENSORY DISCRIMINATION: Utilize those approaches which indicate that the examiner is screening for pain, vibration, light touch, and stereognosis intact, and then record results. .5

SCORE

BONE MARROW ASPIRATION: Place equipment at bedside, assist physician with procedure, and then remove equipment from area. .5

LUMBAR PUNCTURE: Place equipment at bedside, assist physician with procedure, and then remove equipment from area. 7

LIVER BIOPSY: Place equipment at bedside, measure baseline vital signs, assist physician with the procedure, and then remove equipment from area. (All post-procedure vital signs will be counted as routine and separate from the procedure.) 5

PROCTOSCOPY: Upon arrival at patient's area, place equipment, support patient during the procedure; then remove equipment from area. 7

ENDOSCOPY: Upon arrival at patient's area, place equipment, assess baseline vital signs (BP, P, R&T). Support patient during procedure, repeat vital signs; then remove equipment from area. 7

LAVAGE: Place equipment at bedside, secure towel around patient's neck, insert stomach tube, assess placement, lavage gastric contents, remove tube, and then remove equipment from area. 7

PARACENTESIS: Place equipment at bedside, measure vital signs, prepare patient and tray for procedure, support patient during procedure, measure vital signs, and then remove equipment from area. 8

BRONCHOSCOPY: Place equipment at bedside, assist physician with procedure, then remove equipment from area. 7

THORACENTESIS: Place equipment at bedside, obtain vital signs, assist physician and support patient during procedure, repeat vital signs, measure and record aspiration fluids, then remove equipment from area. 9

COLLECTION OF FECES SAMPLE: Upon obtaining feces sample, place sample in collection container, label, and then remove from area. .5

PSYCHOLOGICAL/PATIENT TEACHING:

TEACHING - PREOPERATIVE INSTRUCTION: Upon arrival at bedside, provide instruction on preoperative and postoperative requirements. (Skin preparation, cough and deep breathe, ankle exercise and position change.) 3

TEACHING - DRESSING CHANGE: Upon arrival at bedside, provide instruction on technique of dressing change, skin care and how to recognize abnormal conditions related to disease/injury. 2

TEACHING - ILEOSTOMY/ILEOCONDUIT CARE: Upon arrival at bedside, provide instruction on the purpose, equipment and care of the ileostomy or ileoconduit. 4

TEACHING - COLOSTOMY CARE: Upon arrival at bedside, provide instruction on the purpose, equipment and technique of colostomy irrigation, and colostomy bag care. 3

SCORE

TEACHING - URINE TESTING: Place equipment at bedside, provide instruction on the purpose and technique for the urine testing. .5

TEACHING - INSULIN ADMINISTRATION: Upon arrival at bedside, provide information on dosage, types of insulin, syringe utilization technique, care of equipment, rotation of sites, and specific drug related information. 3

TEACHING - DIABETIC: Upon arrival at bedside, provide information on the disease process and care related to this process. (Signs and symptoms on insulin lack/overdosage, foot care, rotation of injection sites, exercise program, storage of medication, and maintenance of equipment.) (Insulin administration should be measured under teaching insulin administration.) 4

GASTROINTESTINAL:

ENEMA - RETENTION: Place equipment at bedside, position patient, administer solution; then remove equipment from area. .5

ENEMA - CLEANSING: Place equipment at bedside, position patient, lubricate tubing, insert rectal tube, administer solution; then remove equipment from area. 2

COLOSTOMY - IRRIGATION: Place equipment at bedside, remove colostomy bag/dressing, administer irrigation solution, allow for return of fluid and feces, cleanse skin and stoma, reapply colostomy bag/dressing; then remove equipment from area. 8

RESPIRATORY:

RESPIRATORY RESUSCITATION: Place equipment at bedside, Check all equipment, assist physician with insertion of endotracheal/tracheostomy tube, bag breathe as indicated, connect respirator; then remove equipment from area. 11

ENDOTRACHEAL/TRACHEOSTOMY TUBE PRESSURE CUFF: Place equipment at bedside, release/or inflate cuff. Restore equipment for future use. 1

CARDIOVASCULAR/TEMPERATURE REGULATION:

SURGICAL INTRAVENOUS INITIATION, CUT DOWN: Place equipment at bedside, assist physician with procedure as required, connect to intravenous line setup, assess status of intravenous line; then remove equipment from area. 15

SKIN:

DEATH CARE: Place equipment at bedside, prepare patient and cover with shroud. 8

SOAKING HAND: Place equipment at bedside, soak hand in solution basin, remove and towel dry hand, and then remove equipment from area. 3

SOAKING FEET: Place equipment at bedside, soak foot/feet in solution basin, remove and towel dry foot/feet, and remove equipment from area. 2

SKELETAL/NEUROLOGICAL:

SCORE

FOOT BOARD: Place equipment at bedside, position foot board into place .5
and then align and position the extremities.

BED CRADLE: Place equipment at bedside and position bed cradle over .5
patient.

SEIZURE CARE: Upon arrival in the patient's area, place padded tongue 2
blade in position, and support patient during the seizure.

UROLOGICAL/GYNECOLOGICAL:

URINARY BLADDER TRAINING: Upon arrival at bedside, clamp/unclamp .5
catheter, record time and urine output if appropriate.

PERITONEAL DIALYSIS - INITIATION: Place equipment at bedside, assist 11
physician with procedure as required, then remove equipment from area.

PERITONEAL DIALYSIS - EXCHANGE OF DIALYSIS SOLUTIONS: Place equipment 7
at bedside, administer dialysis solution, measure output of dialysis
solution, record results; then remove used equipment from area.

PERITONEAL DIALYSIS - REMOVING DIALYSIS CATHETER: Place equipment at 2
bedside, assist physician with the removal of the dialysis catheter,
apply dressing to area; then remove equipment from area.

CATHETERIZATION - STRAIGHT: Place equipment at bedside, prepare patient 2
and insert catheter, empty bladder and remove straight catheter; then
remove used equipment from area.

VAGINAL/PELVIC EXAMINATION: Assist patient onto examination table, 2
position patient, set up equipment and assist physician with the pro-
cedure; then assist patient in getting off the examination table.

FUNDUS MASSAGE: Upon arrival at bedside, expose patient's lower abdo- .5
minal area, massage fundus and assess height of uterus; then record.

PERINEAL SUTURE CARE: Cleanse area with antiseptic solution, irrigate 1
with water, dry suture area, and apply heat lamp to suture line.

APPENDIX D

Critical Care Patient Classification Tabulation Form

TOTAL POINTS	HOURS OF CARE	CATEGORY OF CARE	NO. OF CASES
>40 - 79	2 - 3	2	
80 - 159	4 - 7	3	
160 - 239	8 - 11	4	
240 - 499	12 - 24	5	
500 - 720	25 - 36+	6	

Nursing
Unit

1

Date _____

Rater's

Signature

Bed

No.	Age	Name of Patient
-----	-----	-----------------

Agg

Name of Patient

Hygiene

Nutrition/
Elimination

Mobility/
Exercise/Safety

Medication

Vital Signs/ Assessment/ Diagnostic Tests

Psychological/
Patient Teaching

Gastrointestinal

Respiratory

Cardiovascular/ Temperature Regulation	
--	--

Skin

Skeletal/
Neurological/EENT

Urological/
Gynecological

Other/Therapeutic Activities/Modalities	
---	--

Total PCIS Score

Category of Care

Critical Care

Bed	No.	Age	Name of Patient
-----	-----	-----	-----------------

[illegible]

APPENDIX E

Methodology for Determining Care Provider Mix for Critical Care

NURSING CARE HOUR STANDARDS
METHODOLOGY FOR DETERMINING CARE PROVIDER MIX
CRITICAL CARE

A. The Percentage Table for Care Provider Mix is a product of Phase II of the Nursing Care Hour Standards Study. During this phase the study team obtained 37,000 on-site measurements at nine medical treatment facilities. These data results were utilized in the development of the personnel percentage table. This percentage table is designed only for use with the Critical Care Patient Classification Tabulation Form.

B. To compute the number of hours of care by provider groups the following steps must be completed.

1. To determine total hours for each patient care indicator complete the next 3 steps.

a. Using the scores from the Critical Care Patient Classification Tabulation Form, (AHS 091-2 Test), add the PCISs down the patient care indicator column. The total gives the total PCIS for that patient care indicator.

b. Multiply that total PCIS for the column by 3 to obtain total minutes for the patient care indicator column.

c. Divide the total minutes for each patient care indicator column by 60 to find total hours for each patient care indicator.

CRITICAL CARE PATIENT CLASSIFICATION TABULATION FORM	TOTAL POINTS	HOURS OF CARE	CATEGORY OF CARE	NO. OF PATIENTS
	240 - 79	2 - 3	2	
	80 - 159	4 - 7	3	
	160 - 239	8 - 11	4	
	240 - 499	12 - 24	5	
	500 - 720	25 - 36+	6	

			Patient Care Indicator Scores															Total PCIS Score	Category of Care
Nursing Unit	Bed No.	Name of Patient	Hygiene	Nutrition/Elaboration	Mobility/Exercise/Safety	Medication	Vital Signs/Assessment/Physiologic Tests	Psychological/Patient Teaching	Gastrointestinal	Respiratory	Cardiovascular/Temperature Regulation	Skin	Skeletal/Neurological/Infect	Urological/Gynecological	Other/Therapeutic Activities/Mobility				
SICU	52	Patient 1	15.0	7.0	23.0	2.0	14.0	31.0	0	31.0	32.0	2.0	0	5	2	21.5	3		
	59	Patient 2	49.0	21.0	36.0	0	100.0	6.0	5.0	41.0	129.0	0	1.0	5.0	0	291.0	5		
	59	Patient 3	34.0	17.0	75.0	6.0	159.0	7.0	7.0	47.0	131.0	22.0	13.0	9.0	0	512.0	6		
	53	Patient 4	24.0	20.0	23.0	1.0	63.0	6.0	0	10.0	27.5	0	0	5.5	0	100.0	4		
	67	Patient 5	16.0	12.0	11.0	1.0	56.0	14.0	6.0	31.0	25.0	2.0	0	7.0	0	151.0	4		
	75	Patient 6	36.0	32.0	44.0	1.0	116.0	10.0	1.0	53.0	96.0	22.0	14.0	10.5	0	471.5	5		
	72	Patient 7	34.0	33.0	4.5	4.5	59.5	5.0	2.0	13.0	23.0	8.0	3.0	2.5	0	215.5	4		
	32	Patient 8	23.0	17.0	19.0	2.5	61.0	9.0	0	30.0	46.0	0	5.0	5.0	0	200.5	4		
	67	Patient 9	34.0	31.0	22.0	2.5	83.0	38.0	.5	60.0	32.0	14.0	6.0	4.0	0	327.0	5		
		Total Points	266.0	190.0	279.0	19.50	774.50	116.0	21.50	321.0	534.50	75.0	49.0	44.0	0	2700.0			
		Total Minutes	798.0	570.0	837.0	58.50	2323.50	348.0	64.50	963.0	1603.50	225.0	147.0	132.0	0	8100.0			
		Total Hours	13.3	9.50	13.95	.98	39.53	5.80	1.08	16.25	26.83	3.75	2.45	2.20	0	135.0			

AHS Form 091-2 (Test)
6 October 1980

Example: Patient Care Indicator-Hygiene

- Add column down for total points = 266 Points
- Multiply total points by 3 - $266 \times 3 = 798$ Minutes
- Divide total minutes by 60 - $798 \div 60 = 13.3$ Hours

2. To determine hours of care provided by each provider group utilize the total hour score from each patient care indicator located on the Critical Care Patient Classification Tabulation Form (AHS 091-2 Test) and the Critical Care Percentage Table for Care Provider Mix which follows:

PERCENTAGE TABLE FOR CARE PROVIDER MIX

CRITICAL CARE

	PROFESSIONAL	TECHNICAL	PARAPROFESSIONAL
HYGIENE	21	71	8
NUTRITION/ ELIMINATION	36	58	6
MOBILITY/ EXERCISE/ SAFETY	34	60	6
MEDICATION	33	12	0
VITAL SIGNS/ ASSESSMENT/ DIAGNOSTIC TEST	49	48	3
PSYCHOLOGICAL/ PATIENT TEACHING	63	35	0
GASTROINTESTINAL	59	41	0
RESPIRATORY	39	53	3
CARDIOVASCULAR/ TEMPERATURE REGULATION	69	30	1
SKIN	41	52	7
SKELETAL/ NEUROLOGICAL/ENT	32	55	13
UROLOGICAL/ GYNECOLOGICAL	27	56	7
OTHER THERAPEUTIC ACTIVITIES/ MODALITIES	46	49	5

Professional =

Registered Professional
Nurses (ANC and DAC 7-13)

Technical =

Licensed Vocational/
Technical Nurses
(DAC 5-6, 91C10-40 and 91B40)

Paraprofessional =

Nursing Assistants
(DAC 3-4 and 91B10-30)

- Select the total hour score for each patient care indicator.
- Select the personnel percentage score for each patient care indicator.
- Multiply the total hour score for each patient care indicator by the appropriate percentage score.

EXAMPLE: Patient Care Indicator - Hygiene

- Total Hour Score = 13.3
- Personnel percentage score for patient care indicator =
Professional 21%
Technician 71%
Paraprofessional 8%
- Multiply total score for PCIS by the personnel percentage score =
 $21\% \times 13.3 = 2.79$ hours by professionals
 $71\% \times 13.3 = 9.44$ hours by technicians
 $8\% \times 13.3 = 1.06$ hours by paraprofessionals

3. To determine total hours of direct care provided by each provider group the following steps must be completed.

a. Add the rows across for the hours by provider group. This will provide you the total number of hours of direct care by each provider group.

	Hygiene	Nutrition/ Elimination	Mobility/ Exercise/Safety	Medication	Vital Signs/ Assessment/ Diagnostic Tests	Psychological/ Patient Teaching	Gastrointestinal	Respiratory	Cardiovascular/ Temperature Regulation	Skin	Skeletal/ Neurological/FENT	Urological/ Gynecological	Other/Therapeutic Activities/ Modalities
TOTAL HOURS	13.3	9.5	12.9	1.0	39.3	5.8	1.0	14.0	24.2	3.2	2.5	2.5	0
PROFESSIONAL	2.79	3.42	4.38	.88	19.25	3.77	.59	6.24	12.49	1.55	.80	.67	0 = 62.83
TECHNICAL	9.44	5.51	7.74	.12	18.86	2.03	.41	9.28	8.04	1.97	1.37	1.65	0 = 66.42
PARAPROFESSIONAL	1.06	.57	.77	0	1.17	0	0	.48	.26	.26	.32	.17	0 = 5.06

EXAMPLE:

Professional

$$2.79 + 3.42 + 4.38 + .88 + 19.25 + 3.77 + .59 + 6.24 + 18.99 + 1.55 + .80 + .67 = 62.83 \text{ TOTAL HOURS BY PROVIDER GROUP}$$

Technical

$$9.44 + 5.51 + 7.74 + .12 + 18.86 + 2.03 + .41 + 9.28 + 8.04 + 1.97 + 1.37 + 1.65 = 66.42 \text{ TOTAL HOURS BY PROVIDER GROUP}$$

Paraprofessional

$$1.06 + .57 + .77 + 1.17 + .48 + .26 + .26 + .32 + .17 = 5.06 \text{ TOTAL HOURS BY PROVIDER GROUP}$$

b. Divide the total hours for each provider group by 8 (hours/shift) to obtain number and mix of care providers required for direct care activities.

EXAMPLE:

$$\begin{aligned} 62.83 \div 8 &= 7.85 \text{ Professional mandays of direct care} \\ 66.42 \div 8 &= 8.30 \text{ Technical mandays of direct care} \\ 5.06 \div 8 &= .63 \text{ Paraprofessional mandays of direct care} \end{aligned}$$

4. The investigator recommends that quarterly computations of provider mix will be sufficient.

HCSD Report #81-009 (Part III)

Nursing Care Hour Standards Study: Part III
Medical/Surgical Patient Classification Subsystem

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Final Report

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NURSING CARE HOUR STANDARDS STUDY: PART III MEDICAL/SURGICAL PATIENT CLASSIFICATION SUBSYSTEM

A. INTRODUCTION

Part III Medical/Surgical Patient Classification Subsystem addresses the development and testing of a multidimensional factor-evaluation designed patient classification subsystem for medical/surgical clinical services. If nursing managers are to make sound administrative decisions on medical/surgical staffing needs, they must measure the appropriate nursing care activities and use the best measuring tool available. The best tool would be an acceptable reference standard, namely, the number of hours of nursing care required to meet safe essential patient care needs with the proper mix by skill level of care providers. The present study has attempted to develop and provide such a tool for medical/surgical clinical services. The approach undertaken also considered the fact that time accountability is the principle commodity in accounting for human resource utilization.

B. OBJECTIVES

The two objectives for Part III Medical/Surgical Patient Classification Subsystem were:

1. To develop a factor-evaluation designed patient classification subsystem for medical/surgical clinical services which would provide a better staffing mix based on quantified direct nursing care requirements.
2. To determine if the Medical/Surgical Patient Classification Subsystem demonstrates validity and reliability.

C. MEDICAL/SURGICAL PATIENT CLASSIFICATION SUBSYSTEM

The format and factor-evaluation design of the Medical/Surgical Patient Classification Subsystem was devised to enable professional nurses in its use to ascertain direct nursing care requirements for inpatients. The Medical/Surgical Patient Classification Subsystem was designed with five components: (1) patient classification instrument mathematical model; (2) patient classification instrument; (3) patient classification instrument instructional information; (4) patient classification tabulation form; and (5) methodology for determining care provider mix. The methodology for the development of each component will be discussed.

1. Medical/Surgical Patient Classification Instrument Mathematical Model.

The medical/surgical patient classification instrument mathematical model (Appendix A) was designed for an automated or manual system. The design of the model delineates the direct nursing care activities, frequency rate for a 24-hour time frame, minimal essential mean tasking time, and the appropriate weighted score. The organization of the mathematical model displays all dimensions of direct patient care and all direct nursing care

activities within each dimension labeled as patient care indicator. Since the primary purpose of the Medical/Surgical Patient Classification Subsystem was to determine the need for direct nursing care resources, then the patient care indicators must represent those direct nursing care activities that have the greatest impact on nursing time. The medical/surgical patient classification instrument mathematical model was developed by utilizing those patient care indicators which were ascertained through timing and observational studies. The medical/surgical patient classification instrument mathematical model was designed with the following patient care indicators:

- a. Hygiene
- b. Nutrition/Elimination
- c. Mobility/Exercise/Safety
- d. Medication
- e. Vital Signs/Assessment/Diagnostic Tests
- f. Psychological/Patient Teaching
- g. Gastrointestinal
- h. Respiratory
- i. Cardiovascular/Temperature Regulation
- j. Skin
- k. Skeletal/Neurological/EENT
- l. Urological/Gynecological

It must be noted that the patient care indicator for medical/surgical and critical care are identical; however, the number and scope of direct nursing care activities vary considerably between these two mathematical models. Likewise, the weighted score for each direct nursing care activity was determined by selecting the best common denominator to fit the total number of direct nursing care activities included within the mathematical model. The weighted factor scale which follows was utilized in developing the medical/surgical patient classification instrument mathematical model: three minutes equals one point; two to three minutes equals one point; and less than two minutes equals 0.5 point. This point conversion scale allows for simple arithmetic summing to quantify the hours of direct nursing care required for medical/surgical inpatients, and even if all of the direct nursing care activities were required for a medical or surgical patient the error rate would not exceed plus or minus thirty minutes.

The medical/surgical patient classification instrument mathematical model was designed for the quantification of direct nursing care requirements for inpatients on the following medical/surgical clinical services:

- a. General Medicine/Internal Medicine
- b. General Surgery
- c. Orthopedics
- d. Neurosurgery
- e. Thoracic Surgery
- f. Urology
- g. Gynecology
- h. Gastroenterology
- i. Oncology
- j. Nephrology
- k. Cardiology
- l. Endocrinology

2. Medical/Surgical Patient Classification Instrument.

The medical/surgical patient classification instrument (Appendix B) was designed for factor evaluation. Extensive comparative analyses were conducted for the determination of the patient care indicators which were considered to represent those direct nursing care activities that have the greatest impact on nursing care time. Based upon these findings thirteen patient care indicators were incorporated within the factor-evaluation designed instrument. Therefore, this type of design allows for the identification of direct nursing care activities for each patient care indicator.

The medical/surgical patient classification instrument was designed to provide a simple tool in which the professional nurse needs only to rate those direct nursing care activities which are appropriate for the patient being rated. The direct nursing care activities scored on the instrument must have been performed by nursing personnel or assistance provided to other staff members performing the activity. If the patient performs self-care activities, then only those direct nursing care activities performed by nursing personnel are scored. The system was designed so that each patient needs only one rating for each 24-hour rating period. The ratings are completed at the end of the 24-hour rating period and are reflective of the preceding 24-hour time frame. The normal rating period was 0700 to 0700 hours; however, patients who were hospitalized less than 24 hours were also rated. In those patients who were within the system less than 24 hours, the

ratings were reflective of the time period that the patient was present within the hospital system.

The instrument was designed to allow for the actual rating of each patient to be accomplished by selecting the frequency rate for each direct nursing care activity that was required during the rating period. Therefore, rating of the patient on the medical/surgical patient classification instrument was accomplished by selecting the frequency rate for the required direct nursing care activity from the options provided on the instrument. Moreover, the instrument was designed so that the frequency rate for each direct nursing care activity has a corresponding point value labeled as weighted score. The format for the medical/surgical patient classification instrument follows the same format as the medical/surgical patient classification instrument mathematical model. As was presented earlier, the patient care indicators were identified as those groupings of direct nursing care activities which most influence the total patient care requirements. Based upon the design of the medical/surgical patient classification instrument it is the total points within each patient care indicator that determines the patient care indicator score (PCIS). The sum of the patient care indicator scores determines the total points, hours of care and category of care for the rated patient.

The medical/surgical patient classification instrument was developed with the following classification scheme as displayed in Table 1.

Table 1
Medical/Surgical Patient Classification Scheme

Total Points	Hours of Care	Category of Care
1 - 39	< 1 thru 1	1
40 - 79	2 thru 3	2
80 - 159	4 thru 7	3
160 - 239	8 thru 11	4
240 - 499	12 thru 24	5

A unique feature considered in the development of the instrument includes the option of including infrequently occurring direct nursing care activities which impact significantly on nursing workload, and can be included in the rating under "other therapeutic activities/modalities."

The medical/surgical patient classification instrument was designed to allow for collection of demographic information. The keypunch spaces one through twelve were provided for data collection which best meets the requirements of the medical treatment facility.

3. Medical/Surgical Patient Classification Instrument Instructional Information.

The medical/surgical patient classification instrument instructional information component (Appendix C) was developed to provide adequate information for the user to consistently apply the same methodology for rating patients' direct care requirements. The organization of the operational definitions and weighted score for each direct nursing care activity follows the same format as the medical/surgical patient classification instrument mathematical model and the medical/surgical patient classification instrument. To reduce the redundancy of the operational definitions provided, each direct nursing care activity also includes: (a) identify and screen the patient; (b) explain the procedure to the patient; (c) raise, lower, or adjust the bed before and after the nursing activity; and (d) clean and straighten area.

In utilizing the patient classification instrument instructional information component the score for each direct nursing care activity applies only to the Medical/Surgical Patient Classification Subsystem for which it was designed. The medical/surgical patient classification instrument instructional information component contains the listing of those infrequently occurring direct nursing care activities which impact significantly on nursing workload, and each of these direct nursing care activities are included in the rating under "other therapeutic activities/modalities." This list of direct nursing care activities is not all-inclusive, as the frequency with which some direct nursing care activities occurred was not sufficient to permit an accurate analysis or generation of a valid score. Moreover, in rating the patients' direct nursing care requirements, only those activities provided are to be utilized for rating the direct care requirements.

4. Medical/Surgical Patient Classification Tabulation Form.

The medical/surgical patient classification tabulation form (Appendix D) was designed for the recording of summary data. After the assessment of direct nursing care requirements has been completed by the professional nurse, the unit clerk can use the medical/surgical patient classification tabulation form to record the patient care indicator scores for each patient. The instructions for recording of patient data are located within the medical/surgical patient classification instructional information component. The data accumulated to this point will provide the necessary information for determining category of care and the hours of care within each patient care indicator for the clinical unit.

The results from extensive data analyses were utilized to design the medical/surgical patient classification tabulation form. These analyses demonstrated that distribution of hours of care within each patient care

indicator and not the category of care determines the mix by skill level of care providers required to meet the rated direct nursing care requirements for medical/surgical inpatients. It must be emphasized that both category of care and hours of care within each patient care indicator can determine man-hour requirements, but only the hours of care within each patient care indicator can determine the best mix by skill level of care providers.

Since all medical treatment facilities do not have automated systems readily available, the medical/surgical patient classification tabulation form was designed to allow for manual computations, as well as keypunching of the patient care indicator scores. Lastly, the medical/surgical patient classification tabulation form was designed with the same format as the medical/surgical patient classification instrument mathematical model, medical/surgical patient classification instrument, and medical/surgical patient classification instrument instructional information components.

5. Methodology For Determining Care Provider Mix For Medical/Surgical.

The methodology for determining care provider mix for medical/surgical (Appendix E) was developed for the purpose of providing the best mix by skill level of care providers. The diversity of direct nursing care activities requires a more complex mix of personnel, therefore, more sophisticated techniques are required to meet these demands. During the timing and observation studies the observers recorded the number and skill level of care providers for each direct nursing care activity. These data were utilized to establish personnel mix percentage scores for each direct nursing care activity. These personnel mix percentage scores were utilized in the development of the personnel percentage table for care provider for medical/surgical patients. The percentage table for provider mix for medical/surgical was developed by collapsing the personnel percentage scores for each direct nursing care activity within each patient care indicator. Table 2 displays the percentage table for care provider mix for medical/surgical.

The mix by skill level of care providers can easily be determined by utilizing the summary data from the medical/surgical patient classification tabulation form and the percentage table for care provider mix for medical/surgical. This approach differs significantly from previous patient classification systems which match category of care with mix of personnel. Present findings demonstrate that the hours of care within each patient care indicator was the determinant for the mix by skill level of care providers and not the category of care. It must be noted that patient classification systems that match category of care with mix of personnel make the major assumption that all patients in the same category of care have the same direct nursing care requirements; hence, the same mix of personnel can meet those care requirements. However, the present findings do not support this assumption.

It is important to note that the percentage table for care provider mix for medical/surgical was developed specifically for medical/surgical clinical services and are not generalizable to other inpatient clinical services. Moreover, the percentage table for care provider mix for medical/surgical applies only to the adult patient.

Table 2
Percentage Table for Care Provider Mix
for Medical/Surgical

	Professional	Technical	Paraprofessional
Hygiene	15	61	24
Nutrition/ Elimination	25	55	20
Mobility/ Exercise/ Safety	26	53	21
Medication	90	9	1
Vital Signs/ Assessment/ Diagnostic Test	30	47	23
Psychological/ Patient Teaching	60	28	12
Gastrointestinal	39	41	20
Respiratory	29	56	15
Cardiovascular/ Temperature Regulation	75	21	4
Skin	23	55	22
Skeletal/ Neurological/EENT	46	33	21
Urological/ Gynecological	37	50	13
Other Therapeutic Activities/ Modalities	54	36	10

D. DATA COLLECTION AND DATA ANALYSIS

1. Validity Determination.

Validity studies were conducted to determine if the Medical/Surgical Patient Classification Subsystem demonstrated content-related and criterion-related validity. Professional nursing judgment was involved in the original design of the medical/surgical patient classification instrument and was again required for validation of the content of the instrument. It is of importance to note that during all data collection efforts, the participants had the option of and were encouraged to indicate inadequacies in the Medical/Surgical Patient Classification Subsystem and suggest modifications.

Having completed the content-related validity testing, correlation coefficients were computed to determine the relationship of documented direct nursing care requirements with the medical/surgical patient classification instrument.

Correlation coefficients for documented direct nursing care requirements with the medical/surgical patient classification instrument mathematical model for two independent testings are displayed in Table 3.

Table 3

Validity: Correlation Coefficients for Documented Direct Nursing Care Requirements with the Medical/Surgical Patient Classification Instrument Mathematical Model

Medical/Surgical	Correlation Coefficients	
	Test 1	Test 2
Direct Nursing Care Requirements Mathematical Model	.99	.99

Observational studies were conducted to determine the relationship of the medical/surgical patient classification instrument to the actual observed and timed measurements of direct nursing care activities. The criterion-related validity coefficients for medical/surgical are displayed in Table 4.

Timed measurements refer to the actual measurements by stopwatch, observed frequencies refer to actual observed frequency rates for each direct nursing care activity, and hours of care were established utilizing the appropriate minimal essential mean tasking time. Assessed requirements refer to the total hours of care established through consensus nursing judgment. As shown in Table 4 the criterion-related validity coefficients for medical/surgical ranged from $r = .97$ to $r = .99$.

Table 4

Criterion-Related Validity Coefficients for Timed Measurements,
Observed Frequencies and Assessed Requirements

Hours of Direct Nursing Care	24-Hour Study Period			
	Mean	SD	95% CI	Pearson's r
Timed Measurements	4.50	3.79	2.21-6.78	.97
Observed Frequencies	5.40	5.90	1.83-8.96	
Timed Measurements	4.50	3.79	2.21-6.78	.98
Assessed Requirements	5.89	6.08	2.21-9.56	
Observed Frequencies	5.40	5.90	1.83-8.96	.99
Assessed Requirements	5.89	6.08	2.21-9.56	

2. Reliability Determination.

Reliability studies were conducted to determine: (a) if the medical/surgical patient classification instrument demonstrated statistically significant interrater reliability for inpatient classification; and (b) if the individual patient care indicator displayed internal consistency.

Prior to initiation of the interrater reliability studies, the professional nurse raters received an orientation to and standardized instructions about the instruments used in the study. A two-hour orientation period was held for group presentation, followed by individual orientation by the project officer. The raters were given a minimum of ten days in which to practice rating patients using the Medical/Surgical Patient Classification Subsystem.

A schedule of data collection for the medical and surgical clinical units was devised to allow for rating of patients on one preselected day per week. The study was conducted over an eight-week period with eight data collection days. The time-span schedule, commencing in September 1980 and ending in January 1981, required four months to complete. The data collection periods were staggered to allow for the project officer to initiate the study within four medical treatment facilities as follows: William Beaumont Army Medical Center; Eisenhower Army Medical Center; Darnall US Army Community Hospital, Fort Hood; and Womack US Army Community Hospital, Fort Bragg.

Eight data collection periods were conducted within the four medical treatment facilities. Ratings were completed on the entire inpatient population of all adult medical and surgical units. Each of the 3980 inpatients were rated by independent, trained pairs of professional nurse raters. In order to establish a level of quality control for the data collection efforts at the unit level, the forms were collected by a facility project officer. The facility project officer was responsible for checking the instruments for completeness, legibility, reconstruction of any missing data and pairing the match pairs of data from the two professional nurse raters. At the end of each week, the facility project officer mailed the completed instruments to HCSD using the preaddressed envelopes provided by HCSD. The HCSD staff edited each instrument and recomputed all scores to assure accuracy prior to coding of data for keypunching.

The population consisted of 2585 males and 1395 females with a mean age of 40 years. A description of the patient population is presented in order to provide a framework for the analyses of the study results. The category of care by age group for rater one vs rater two is shown in Table 5.

Table 5
Category of Care by Age Group for Rater One vs Rater Two
N = 3980

		Age Group							
		4	5	6	7	8	9		
Category of Care	1	Rater One	15	815	891	260	103	22	Age Groups 4 = 12 thru 15 years 5 = 16 thru 25 years 6 = 26 thru 55 years 7 = 56 thru 65 years 8 = 66 thru 75 years 9 = 76 thru 100 years
		Rater Two	18	803	879	283	108	31	
	2	Rater One	12	384	483	213	112	48	
		Rater Two	11	401	490	171	102	43	
	3	Rater One	7	147	188	121	53	38	
		Rater Two	5	140	204	139	62	35	
	4	Rater One	0	6	21	13	10	4	
		Rater Two	0	9	12	16	7	4	
	5	Rater One	0	2	5	4	2	1	
		Rater Two	0	1	2	2	1	0	

The breakdown of category of care by sex of the patients for rater one vs rater two are shown in Table 6.

Table 6

Category of Care by Sex of the Patient for Rater One vs Rater Two

		Sex of Patient	
		Male	Female
1	Rater One	1330	776
	Rater Two	1359	764
2	Rater One	857	395
	Rater Two	819	399
3	Rater One	352	202
	Rater Two	367	218
4	Rater One	36	18
	Rater Two	35	14
5	Rater One	9	5
	Rater Two	5	1
N		2535	1395

The descriptive data of the patient care indicator scores for rater one vs rater two by sex of the total population are shown in Table 7.

Table 7

Descriptive Data of Patient Care Indicator Scores for Rater One vs Rater Two by Sex

		Mean	SD	N
Male	Rater One	48.26	39.87	2585
	Rater Two	47.33	38.09	
Female	Rater One	46.30	36.95	1395
	Rater Two	46.95	35.77	

Category of care distribution by days of the week for rater one vs rater two are shown in Table 8.

Table 8

Category of Care by Days of the Week for Rater One vs Rater Two
N = 3890

		Days of Week							
		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
Category of Care	1	Rater One	418	278	408	299	383	160	160
		Rater Two	443	279	388	314	399	140	160
	2	Rater One	276	194	191	162	176	98	155
		Rater Two	255	188	204	146	157	123	145
	3	Rater One	125	80	84	83	26	75	81
		Rater Two	123	89	92	84	29	73	95
	4	Rater One	10	13	9	0	2	8	12
		Rater Two	9	10	8	2	4	7	8
	5	Rater One	2	3	0	2	2	3	2
		Rater Two	1	2	0	0	0	1	2

In the determination of interrater reliability two sets of ratings, one for total score and one for category of care were obtained from the assessment of each of the 3980 inpatients by two independent trained raters representing four medical treatment facilities. The data were analyzed using the Pearson's correlation coefficient with a resultant reliability coefficient for total score and category of care. Table 9 displays the medical/surgical patient classification instrument frequency distribution: rater one vs rater two for category of care. Pearson's correlation coefficient for category of care rater one vs rater two, $r = .82$.

Table 9

Medical/Surgical Patient Classification Instrument
Frequency Distribution: Rater One vs Rater Two for Category of Care

N = 3980

		Category of Care for Rater Two				
		1	2	3	4	5
Category of Care for Rater One	1	1890	203	11	0	0
	2	215	886	150	1	0
	3	15	126	403	10	0
	4	0	2	21	31	0
	5	1	1	0	6	6

Pearson's r for Category of Care Rater One vs Rater Two, $r = .82$

Concurrently, Table 10 displays the correlation coefficient for total patient care indicator score (PCIS) by category of care. Pearson's correlation coefficient for total PCIS rater one vs. rater two across categories, $r = .85$. In addition, all coefficients for total score and category of care were significant ($p < .001$).

Table 10
Medical/Surgical Patient Classification Instrument
Total Patient Care Indicator Score (PCIS) by Category of Care

Category of Care	PCIS		Mean	SD	95% CI	N
	Rater One	Rater Two				
1	Rater One	1-39	22.21	9.17	21.81-22.60	2121
	Rater Two		22.76	15.34	22.11-23.41	2106
2	Rater One	40-79	56.52	13.33	55.47-57.56	1252
	Rater Two		56.40	11.79	55.74-57.06	1218
3	Rater One	80-159	104.71	20.11	103.03-106.39	554
	Rater Two		102.28	19.09	100.79-103.83	585
4	Rater One	160-239	183.31	18.66	178.21-188.40	54
	Rater Two		189.66	22.90	183.01-196.31	48
5	Rater One	240-499	279.00	108.93	218.99-339.01	14
	Rater Two		324.25	93.33	226.31-422.19	6

Pearson's r for total PCIS rater one vs rater two across categories, $r = .85$.

To establish internal consistency of the medical/surgical patient classification instrument, two independent raters' patient care indicator scores were analyzed to determine if the individual responses to the various patient care indicators were consistent. Correlation coefficients were used to indicate the degree to which variation in the patient care indicator scores for rater one was related to variation in the patient care indicator scores for rater two. Correlation coefficients were used to indicate the strength of the relationship between rater one scores and rater two scores. Tests of significance, for each coefficient, derived from students' t with $N-2$ degrees of freedom indicate the level of statistical significance for all coefficients. All coefficients, with the exception of four, achieved significance at the .05 level or better, indicating significant agreement between raters on patient care indicators. These correlated findings are shown in Table 11.

Table 11
MEDICAL/SURGICAL PATIENT CLASSIFICATION INSTRUMENT
INTERCORRELATIONS OF PATIENT CARE INDICATOR SCORES

	Hygiene	Nutrition/ Elimination	Mobility/ Exercise/ Safety	Vital Signs /Assessment/ Diagnostic Tests	Psychological/ Patient Teaching	Gastroin- testinal	Respira- tory	Cardio- vascular/ Tempera- ture Reg- ulation	Skin	Skeletal/ Neurolo- gical/ ENT	Urolog- ical/ Gyneco- logical	Other Therapeu- tic Activ- ities/ Modalities
Category 1 (<1-1 hour) (df = 268)	r=.733 p<.001	r=.553 p<.001	r=.691 p<.001	r=.810 p<.001	r=.566 p<.001	r=.560 p<.001	r=.798 p<.001	r=.799 p<.001	r=.553 p<.001	r=.771 p<.001	r=.611 p<.001	No Entries
Category 2 (2-3 hours) (df = 131)	r=.618 p<.001	r=.664 p<.001	r=.633 p<.001	r=.873 p<.001	r=.813 p<.001	r=.636 p<.001	r=.784 p<.001	r=.902 p<.001	r=.050 p<.001	r=.814 p<.001	r=.881 p<.001	r=.577 p<.001
Category 3 (4-7 hours) (df = 62)	r=.743 p<.001	r=.803 p<.001	r=.702 p<.001	r=.890 p<.001	r=.957 p<.001	r=.685 p<.001	r=.198 p n/s	r=.714 p<.001	r=.742 p<.001	r=.693 p<.001	r=.633 p<.001	r=.318 p<.02
Category 4 (8-11 hours) (df = 45)	r=.891 p<.001	r=.628 p<.001	r=.557 p<.001	r=.849 p<.001	r=.775 p<.001	r=.843 p<.001	r=.618 p<.001	r=.794 p<.001	r=.867 p<.001	r=.642 p<.001	r=.728 p<.001	r=.278 p<.001
Category 5 (12-24 hours) (df = 7)	r=.285 p n/s	r=.718 p<.05	r=.832 p<.01	r=.691 p n/s	r=.428 p n/s	r=.962 p<.001	r=.947 p<.001	r=.952 p<.001	r=.823 p<.01	r=.928 p<.001	r=.821 p<.01	r=.842 p<.01

E. CONCLUSIONS

The Medical/Surgical Patient Classification Subsystem has been developed and tested through four years of rigorous field research. This quantitative subsystem measures direct nursing care activities and determines the best mix by skill level of care providers for medical/surgical patients. The Medical/Surgical Patient Classification Subsystem utilizes the factor-evaluation design, is multidimensional, and is designed for automated or manual implementation. Extensive validity and reliability studies demonstrate that the Medical/Surgical Patient Classification Subsystem is valid and reliable.

APPENDIX A
Medical/Surgical Patient Classification Instrument
Mathematical Model

MEDICAL/SURGICAL PATIENT CLASSIFICATION INSTRUMENT

MATHEMATICAL MODEL

ACTIVITY (MEAN)

(FREQUENCY) TOTAL SCORE WEIGHTED SCORE

HYGIENE:

Bathing, Complete (20.1646)	(1) 20.1646 7	(2) 40.3292 13	(3) 60.4938 20			
Bathing, Partial (12.1010)	(1) 12.1010 4					
Bathing, Utensils Provided (2.5201)	(1) 2.5201 1					
Sitting Shower/Shower with Assistance/Tub Bath (17.4007)	(1) 17.4007 6	(2) 34.8014 12	(3) 52.2021 17			
AM Care (6.9666)	(1) 6.9666 2					
AM Care, Partial/ Utensils Provided (3.4290)	(1) 3.4290 1					
Oral Hygiene (3.2428)	(1) 3.2428 1	(2) 6.4856 2	(3) 9.7284 3	(6) 19.4568 6	(9) 29.1852 10	(12) 38.9136 13
Skin Care/Back Rub (3.3675)	(1) 3.3675 1	(2) 6.7350 2	(3) 10.1025 3	(6) 20.2050 7	(9) 30.3075 10	(12) 40.4100 13
PM Care (10.6934)	(1) 10.6934 4					
Shaving (6.2501)	(1) 6.2501 2					
Shampoo (9.9967)	(1) 9.9967 3					
Occupied Bed (9.6977)	(1) 9.6977 3	(2) 19.3954 6	(3) 29.0931 10	(4) 38.7908 13	(5) 48.4885 16	(6) 58.1862 19

ACTIVITY
(MEAN)

(FREQUENCY)
TOTAL SCORE
WEIGHTED SCORE

Unoccupied Bed (6.0472)	(1) 6.0472 2	(2) 12.0944 4	(3) 18.1416 6	(4) 24.1888 8	(5) 30.2360 10	(6) 36.2832 12
Changing Bed Linen Protector/Chux (1.0063)	(1) 1.0063 .5	(2) 2.0126 1	(3) 3.0189 1	(6) 6.0378 2	(9) 9.0567 3	(12) 12.0756 4

NUTRITION/ELIMINATION:

Fluid/Snack (.8999)	(1) .8999 .5	(3) 2.6997 1	(6) 5.3994 2	(9) 8.0991 3	(12) 10.7988 4	(24) 21.5976 7
Feeding (16.1591)	(1) 16.1591 5	(2) 32.3182 11	(3) 48.4773 16			
Serving Meal Tray, Preparation Required (2.6073)	(1) 2.6073 1	(2) 5.2146 2	(3) 7.8219 3			
Serving Meal Tray, No Preparation Required (.3881)	(1) .3881 .5	(2) .7762 .5	(3) 1.1643 .5			
Special Feeding - Nasogastric/Gastrostomy (3.7195)	(1) 3.7195 1	(2) 7.4390 2	(3) 11.1585 4	(6) 22.3170 7	(9) 33.4755 11	(12) 44.6340 15
Special Feeding - Hyperalimentation/ Intravenous (6.0009)	(1) 6.0009 2	(2) 12.0018 4	(3) 18.0027 6	(4) 24.0036 8	(5) 30.0045 10	(6) 36.0054 12
Measuring and Recording Intake (.8583)	(1) .8583 .5	(3) 2.5749 1	(6) 5.1498 2	(9) 7.7247 3	(12) 10.2996 3	(24) 20.5992 7
Measuring and Recording Output - Urine/Liquid Feces/Vomit/Drainage Bottles, All Types (1.1523)	(1) 1.1523 .5	(3) 3.4569 1	(6) 6.9138 2	(9) 10.3707 3	(12) 13.8276 5	(24) 27.6552 9
Giving a Bedpan (2.5998)	(1) 2.5998 1	(2) 5.1996 2	(3) 7.7994 3	(6) 15.5988 5	(9) 23.3982 8	(12) 31.1976 10
Giving a Urinal (1.9695)	(1) 1.9695 .5	(2) 3.9390 1	(3) 5.9085 2	(6) 11.8170 4	(9) 17.7255 6	(12) 23.6340 8

ACTIVITY
(MEAN)

(FREQUENCY)
TOTAL SCORE
WEIGHTED SCORE

Incontinent Care (7.1308)	(1) 7.1308 2	(2) 14.2616 5	(3) 21.3924 7	(6) 42.7848 14	(9) 64.1772 21	(12) 85.5696 29
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MOBILITY/EXERCISE/SAFETY:

Changing Patient's Position in Bed (2.1266)	(1) 2.1266 1	(3) 6.3798 2	(6) 12.7596 4	(9) 19.1394 6	(12) 25.5192 9	(24) 51.0384 17
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Adjusting Position of Bed (.7158)	(1) .7158 .5	(3) 2.1474 1	(6) 4.2948 1	(9) 6.4422 2	(12) 8.5896 3	(24) 17.1792 6
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Adjusting Restraint (1.2751)	(1) 1.2751 .5	(3) 3.8253 1	(6) 7.6506 3	(9) 11.4759 4	(12) 15.3012 5	(24) 30.6024 10
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Exercise - Active/ Passive (6.5687)	(1) 6.5687 2	(2) 13.1374 4	(3) 19.7061 7	(6) 39.4122 13	(9) 59.1183 20	(12) 78.8244 26
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Mobility - Bed to Stretcher/Bed to Chair/ Ambulating First Time (4.9972)	(1) 4.9972 2	(2) 9.9944 3	(3) 14.9916 5	(6) 29.9832 10	(9) 44.9748 15	(12) 59.9664 20
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Mobility - Assistance While Walking/Bedside Commode (3.7348)	(1) 3.7348 1	(2) 7.4696 2	(3) 11.2044 4	(6) 22.4088 7	(9) 33.6132 11	(12) 44.8175 15
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Mobility - Bed to Floor/ Sitting on Side of Bed (1.7997)	(1) 1.7997 .5	(2) 3.5994 1	(3) 5.3991 2	(6) 10.7982 4	(9) 16.1973 5	(12) 21.5964 7
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Turning Frame, All Types (9.0256)	(1) 9.0256 3	(2) 18.0512 6	(3) 27.0768 9	(6) 54.1536 18	(9) 81.2304 27	(12) 108.3072 36
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Adjusting Siderail (.3696)	(4) 1.4784 .5	(8) 2.9568 1	(12) 4.4352 1	(24) 8.8704 3	(36) 13.3056 4	(48) 17.7408 6
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MEDICATION:

Oral (.8085)	(2) 1.6170 .5	(3) 2.4255 1	(6) 4.8510 2	(12) 9.7020 3	(18) 14.5530 5	(24) 19.4040 6
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Intramuscular (1.2259)	(1) 1.2259 .5	(2) 2.4518 1	(3) 3.6777 1	(4) 4.9036 2	(5) 6.1295 2	(6) 7.3554 2
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ACTIVITY
(MEAN)

(FREQUENCY)
TOTAL SCORE
WEIGHTED SCORE

Topical (1.2234)	(1) 1.2234 .5	(2) 2.4468 1	(3) 3.6702 1	(4) 4.8936 2	(5) 6.1170 2	(6) 7.3404 2
Sublingual (.4778)	(1) .4778 .5	(2) .9556 .5	(3) 1.4334 .5	(4) 1.9112 .5	(5) 2.3890 1	(6) 2.8668 1
Subcutaneous (.9010)	(1) .9010 .5	(2) 1.8020 .5	(3) 2.7030 1	(4) 3.6040 1	(5) 4.5050 2	(6) 5.4060 2
Suppository - Rectal/ Vaginal (1.4799)	(1) 1.4799 .5	(2) 2.9598 1	(3) 4.4397 1	(4) 5.9196 2	(5) 7.3995 2	(6) 8.8794 3

VITAL SIGNS/ASSESSMENT/DIAGNOSTIC TESTS:

Blood Pressure, Manual (1.0388)	(1) 1.0388 .5	(3) 3.1164 1	(6) 6.2328 2	(9) 9.3492 3	(12) 12.4656 4	(24) 24.9312 8
Oral Temperature, Pulse and Respirations (1.2903)	(1) 1.2903 .5	(3) 3.8709 1	(6) 7.7580 3	(9) 11.6127 4	(12) 15.4836 5	(24) 30.9672 10
Pulse - Radial/Brachial/ Apical/Pedal/Femoral/ Popliteal (1.0113)	(1) 1.0113 .5	(3) 3.0339 1	(6) 6.0678 2	(9) 9.1017 3	(12) 12.1356 4	(24) 24.2712 8
Respirations (.6605)	(1) .6605 .5	(3) 1.9815 .5	(6) 3.9630 1	(9) 5.9445 2	(12) 7.9260 3	(24) 15.8520 5
Temperature - Oral/ Rectal/Axillary (1.2370)	(1) 1.2370 .5	(3) 3.7110 1	(6) 7.4220 2	(9) 11.1330 4	(12) 14.8440 5	(24) 29.6880 10
Rhythm Strip/Monitor (.8610)	(1) .8610 .5	(3) 2.5830 1	(6) 5.1660 2	(9) 7.7490 3	(12) 10.3320 3	(24) 20.6640 7
Adjusting Cardiac Monitor/ Connecting Leads/Reset Alarm (.9458)	(1) .9458 .5	(3) 2.8374 1	(6) 5.6748 2	(9) 8.5122 3	(12) 11.3496 4	(24) 22.6992 8
Pulmonary/Bowel Assessment (1.5929)	(1) 1.5929 .5	(3) 4.7787 2	(6) 9.5574 3	(9) 14.3361 4	(12) 19.1148 5	(24) 38.2296 13
Pupil Reflexes (.6611)	(1) .6611 .5	(3) 1.9833 .5	(6) 3.9666 1	(9) 5.9499 2	(12) 7.9332 3	(24) 15.8664 5

ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE					
Mental Alertness (.9056)	(1) .9056 .5	(3) 2.7168 1	(6) 5.4336 2	(9) 8.1504 3	(12) 10.8672 4	(24) 21.7344 7
Orientation (.9941)	(1) .9941 .5	(3) 2.9823 1	(6) 5.9646 2	(9) 8.9469 3	(12) 11.9292 4	(24) 23.8584 8
Sensory Discrimination/ Motor or Sensory Test (1.2654)	(1) 1.2654 .5	(3) 3.7962 1	(6) 7.5924 3	(9) 11.3886 4	(12) 15.1848 5	(24) 30.3696 10
Monitor Leads Application (2.1090)	(1) 2.1090 1	(3) 6.3270 2	(6) 12.6540 4	(9) 18.9810 6		
Heart Sounds Assessment (1.2845)	(1) 1.2845 .5	(2) 2.5690 1	(3) 3.8535 1	(4) 5.1380 2	(5) 6.4225 2	(6) 7.7070 3
12 Lead ECG/Rhythm Strip - ECG Machine (9.0537)	(1) 9.0537 3	(2) 18.1074 6	(3) 27.1611 9	(4) 36.2148 12	(5) 45.2685 15	(6) 54.3222 18
Ambulatory Weight (1.2309)	(1) 1.2309 .5	(2) 2.4618 1				
Bed Scale Weight (5.6879)	(1) 5.6879 2	(2) 11.3758 4				
Urine Testing - Protein/ Specific Gravity (.7365)	(1) .7365 .5	(2) 1.4730 .5	(3) 2.2095 1	(4) 2.9460 1	(6) 4.4190 1	(12) 8.8380 3
Urine Testing - Sugar and Acetone (1.7777)	(1) 1.7777 .5	(2) 3.5554 1	(3) 5.3331 2	(4) 7.1108 2	(6) 10.6662 4	(12) 21.3324 7
Guaiac Testing/Collection of Feces Sample (1.3911)	(1) 1.3911 .5	(2) 2.7822 1	(3) 4.1733 1	(4) 5.5644 2	(6) 8.3466 3	(12) 16.6932 6
Situational Observation (28.2554)	(1) 28.2554 9	(2) 56.5108 19	(3) 84.7662 28	(4) 113.0216 38	(5) 141.2770 47	(6) 169.5324 57
PSYCHOLOGICAL/PATIENT TEACHING:						
Explanation of Procedures and Tests (1.7433)	(1) 1.7433 .5	(2) 3.4866 1	(3) 5.2299 2	(6) 10.4598 3	(?) 15.6897 5	(12) 20.9196 7
Orientation to Clinical Unit (4.7997)	(1) 4.7997 2	(2) 9.5994 3	(3) 14.3991 5			

ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE					
Answering Patient's Question (1.0121)	(3) 3.0363 1	(6) 6.0726 2	(12) 12.1452 4	(18) 18.2178 6	(24) 24.2904 8	(48) 48.5808 16
Visiting with Patient/ Purposeful Interaction (2.1036)	(3) 6.3108 2	(6) 12.6216 4	(12) 25.2432 8	(18) 37.8648 13	(24) 50.4864 17	(48) 100.9728 34
Teaching - Disease/ Condition Related (6.1507)	(1) 6.1507 2	(2) 12.3014 4	(3) 18.4521 6	(6) 36.9042 12	(9) 55.3563 18	(12) 73.8084 25
Teaching - Diagnostic Test/Urine Testing (1.1692)	(1) 1.1692 .5	(2) 2.3384 1	(3) 3.5076 1	(4) 4.6768 2	(5) 5.8460 2	(6) 7.0152 2
Teaching - Dietary Explanation (2.8633)	(1) 2.8633 1	(2) 5.7266 2	(3) 8.5899 3	(4) 11.4532 4	(5) 14.3165 5	(6) 17.1798 6
Teaching - Blow Bottles/ Incentive Spirometer (3.5971)	(1) 3.5971 1	(2) 7.1942 2	(3) 10.7913 4	(4) 14.3884 5	(5) 17.9855 6	(6) 21.5826 7
Teaching - Dressing Change (6.4700)	(1) 6.4700 2	(2) 12.9400 4	(3) 19.4100 6			
Teaching - Ileostomy/ Ileoconduit Care (12.9100)	(1) 12.9100 4	(2) 25.8200 9	(3) 38.7300 13			
Teaching - Preoperative/ Diabetic/Insulin Admin- istration/Colostomy Care (9.4146)	(1) 9.4146 3	(2) 18.8292 6				
Teaching - Medication Administration (19.5881)	(1) 19.5881 7					

GASTROINTESTINAL:

Nasogastric Tube - Irrigation (1.5874)	(1) 1.5874 .5	(2) 3.1748 1	(3) 4.7622 2	(6) 9.5244 3	(9) 14.2866 5	(12) 19.0488 6
Nasogastric Tube - Instillation (2.4201)	(1) 2.4201 1	(2) 4.8402 2	(3) 7.2603 2	(6) 14.5206 5	(9) 21.7809 7	(12) 29.0412 10
Nasogastric Tube - Insertion (8.0006)	(1) 8.0006 3	(2) 16.0012 5	(3) 24.0018 8	(4) 32.0024 11	(5) 40.0030 13	(6) 48.0036 16

ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE					
Nasogastric Tube - Removal (1.4648)	(1) 1.4648 .5	(2) 2.9296 1				
Enema - Cleansing (4.7160)	(1) 4.7160 2	(2) 9.4320 3	(3) 14.1480 5			
Enema - Retention (1.8452)	(1) 1.8452 .5	(2) 3.6904 1				
Colostomy Irrigation (23.3914)	(1) 23.3914 8					
Fecal Impaction Assessment/Removal (2.6187)	(1) 2.6187 1					
Dressing Change, Colostomy/Ileostomy/ Ileoconduit (8.1367)	(1) 8.1367 3	(2) 16.2734 5	(3) 24.4101 8	(4) 32.5468 11	(5) 40.6835 14	(6) 48.8202 16

RESPIRATORY:

Oxygen Administration (1.0541)	(1) 1.0541 .5	(3) 3.1623 1	(6) 6.3246 2	(9) 9.4869 3	(12) 12.6492 4	(24) 25.2984 8
Cough and Deep Breathe (2.2805)	(1) 2.2805 1	(2) 4.5610 2	(3) 6.8415 2	(6) 13.6830 5	(9) 20.5245 7	(12) 27.3660 9
Chest Pulmonary Therapy - Frappage with Postural Drainage (3.6600)	(1) 3.6600 1	(2) 7.3200 2	(3) 10.9800 4	(6) 21.9600 7	(9) 32.9400 11	(12) 43.9200 15
Blow Bottles/ Incentive Spirometer (3.2065)	(1) 3.2065 1	(2) 6.4130 2	(3) 9.6195 3	(6) 19.2390 6	(9) 28.8585 10	(12) 38.4780 13
IPPB Treatment (7.9892)	(1) 7.9892 3	(2) 15.9784 5	(3) 23.9676 8	(6) 47.9352 16	(9) 71.9028 24	(12) 95.8704 32
Suctioning - Oral (1.6606)	(1) 1.6606 .5	(2) 3.3212 1	(3) 4.9818 2	(6) 9.9636 3	(9) 14.9454 5	(12) 19.9272 7
Suctioning - Tracheostomy/ Naso-Tracheal/Endotracheal (3.3998)	(1) 3.3998 1	(2) 6.7996 2	(3) 10.1994 3	(6) 20.3988 7	(9) 30.5982 10	(12) 40.7976 14

ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE					
Tracheostomy Care - Cleaning Cannula/ Dressing Change (6.2021)	(1) 6.2021 2	(2) 12.4042 4	(3) 18.6063 6	(6) 37.2126 12	(9) 55.8189 19	(12) 74.4252 25
Positioning for X-Ray (3.7549)	(1) 3.7549 1	(2) 7.5098 3	(3) 11.2647 4			
Chest Tube - Insertion (27.4300)	(1) 27.4300 9	(2) 54.8600 18				
Chest Tube - Care (11.4078)	(1) 11.4078 4	(2) 22.8156 8				
Chest Tube - Changing Bottles (9.4762)	(1) 9.4762 3	(2) 18.9524 6				
Chest Tube - Removal (5.6418)	(1) 5.6418 2	(2) 11.2836 4				

CARDIOVASCULAR/TEMPERATURE REGULATION:

Venipuncture - Blood Sample (3.5175)	(1) 3.5175 1	(2) 7.0350 2	(3) 10.5525 3	(6) 21.1050 7	(9) 31.6575 11	(12) 42.2100 14
Arterial Puncture - Blood Gases (5.4705)	(1) 5.4705 2	(2) 10.9410 4	(3) 16.4115 5			
Venipuncture - Blood Culture (4.9744)	(1) 4.9744 2	(2) 9.9488 3	(3) 14.9232 5			
Intravenous Infusion - Flow Rate (.7528)	(3) 2.2584 1	(6) 4.5168 2	(9) 6.7752 2	(12) 9.0336 3	(18) 13.5504 5	(24) 18.0672 6
Intravenous Infusion - IV Push Medication/Piggy- Back Medication/Changing IV Bottle (1.8038)	(1) 1.8038 .5	(3) 5.4114 2	(6) 10.8228 4	(12) 21.6456 7	(18) 32.4684 11	(24) 43.2912 14
Intravenous Infusion - Initiating/IV Catheter Care (9.4769)	(1) 9.4769 3	(2) 18.9538 6	(3) 28.4307 9	(4) 37.9076 13	(5) 48/3945 16	(6) 56.8614 19
Intravenous Infusion - Infusion Pump Setup/ Termination (3.4434)	(1) 3.4434 1	(2) 6.8868 2	(3) 10.3302 3	(4) 13.7736 5	(5) 17.2170 6	(6) 20.6604 7

ACTIVITY
(MEAN)

(FREQUENCY)
TOTAL SCORE
WEIGHTED SCORE

Intravenous Infusion - Platelets/Plasma/Blood (3.3270)	(1) 3.3270 1	(2) 6.6540 2	(3) 9.9810 3	(4) 13.3080 4	(5) 16.6350 6	(6) 19.9620 7
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Elastic Stockings/ Ace Bandage (3.4471)	(1) 3.4471 1	(2) 6.8942 2	(3) 10.3413 3
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Hypothermia/Hyper- thermia Treatment (5.3300)	(1) 5.3300 2
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SKIN:

Application of K-Pad/Heat Lamp (1.5317)	(1) 1.5317 .5	(2) 3.0634 1	(3) 4.5951 2	(6) 9.1902 3	(9) 13.7853 5	(12) 18.3804 6
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Decubitus Care/Soaking Hand/Cold Compress (8.8069)	(1) 8.8069 3	(2) 17.6138 6	(3) 26.4207 9	(6) 52.8414 18	(9) 79.2621 26	(12) 105.6828 35
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Small Dressing Change, < 4" x 8" /Soaking Feet/ Suture-Skin Clip Removal, < 15 (6.3355)	(1) 6.3355 2	(2) 12.6710 4	(3) 19.0065 6	(4) 25.3420 8	(6) 38.0130 13	(9) 57.0195 19
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Large Dressing Change, 4" x 8" >/Wound Irrigation (12.0525)	(1) 12.0525 4	(2) 24.1050 8	(3) 36.1575 12	(4) 48.2100 16	(6) 72.3150 24	(9) 108.4725 36
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Reinforcing Dressing (3.5442)	(1) 3.5442 1	(2) 7.0884 2	(3) 10.6326 4	(4) 14.1768 5	(6) 21.2652 7	(9) 31.8978 11
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Wound Culture/Hot Compress (2.5428)	(1) 2.5428 1	(2) 5.0856 2	(3) 7.6284 3	(4) 10.1712 3	(5) 12.7140 4	(6) 15.2568 5
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Sitz Bath/Surgical Prep, Local (10.8094)	(1) 10.8094 4	(2) 21.6188 7	(3) 32.4282 11	(4) 43.2376 14	(5) 54.0470 18	(6) 54.8564 22
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Suture/Skin Clip Removal, 15 or more (14.4313)	(1) 14.4313 5	(2) 28.8626 10	(3) 43.2939 14
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Surgical Prep, 3-way (16.6240)	(1) 16.6240 6
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Air Floatation/Alter- nating Pressure Mattress (6.5762)	(1) 6.5762 2
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ACTIVITY
(MEAN)

(FREQUENCY)
TOTAL SCORE
WEIGHTED SCORE

Isolation, Gowning & Gloving (1.4659)	(6) 8.7954 3	(9) 13.1931 4	(12) 17.5908 6	(18) 26.3862 9	(24) 35.1816 12	(48) 70.3632 23
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SKELETAL/NEUROLOGICAL/ENT:

Pin/Head Tongs Care (6.7835)	(1) 6.7835 2	(2) 13.5670 5	(3) 20.3505 7	(4) 27.1340 9	(5) 33.9175 11	(6) 40.7010 14
Circulation Check (.6672)	(1) .6672 .5	(3) 2.0016 1	(6) 4.0032 1	(9) 6.0048 2	(12) 8.0064 3	(24) 16.0128 5
Cast Care (1.1165)	(1) 1.1165 .5	(3) 3.3495 1	(6) 6.6990 2	(9) 10.0485 3	(12) 13.3980 4	(24) 26.7960 9
Ice Pack (.8001)	(1) .8001 .5	(3) 2.4003 1	(6) 4.8006 2	(9) 7.2009 2	(12) 9.6012 3	(24) 19.2024 6
Extremity Traction - Application (4.1400)	(1) 4.1400 1	(2) 8.2800 3	(3) 12.4200 4	(6) 24.8400 8	(9) 37.2600 12	(12) 49.6800 17
Extremity Traction - Adjust (2.5445)	(1) 2.5445 1	(2) 5.0890 2	(3) 7.6335 3	(6) 15.2670 5	(9) 22.9005 8	(12) 30.5340 10
Extremity Elevation (.9140)	(1) .9140 .5	(2) 1.8280 .5	(3) 2.7420 1	(6) 5.4840 2	(9) 8.2260 3	(12) 10.9680 4
Eye Care (1.7834)	(1) 1.7834 .5	(2) 3.5668 1	(3) 5.3502 2	(6) 10.7004 4	(9) 16.0506 5	(12) 21.4008 7
Instillation of Drops - Eye/Ear/Nose (.5992)	(1) .5992 .5	(2) 1.1984 .5	(3) 1.7976 .5	(4) 2.3968 1	(5) 2.9960 1	(6) 3.5952 1
Culture - Sputum (2.4563)	(1) 2.4563 1	(2) 4.9126 2	(3) 7.3689 2			
Culture - Nose/Throat (.4417)	(1) .4417 .5	(2) .8834 .5				

UROLOGICAL/GYNECOLOGICAL:

Condom Catheter Application (3.2076)	(1) 3.2076 1	(2) 6.4152 2	(3) 9.6228 3	(4) 12.8304 4	(6) 19.2456 6	(9) 28.8684 10
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ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE					
Catheterization - Foley (7.9674)	(1) 7.9674 3	(2) 15.9348 5	(3) 23.9022 8			
Catheterization - Straight (6.4924)	(1) 6.4924 2	(2) 12.9848 4	(3) 19.4772 6	(4) 25.9696 9	(5) 32.4620 11	(6) 38.9544 13
Foley Catheter Care/ Foley Catheter Removal (3.8739)	(1) 3.8739 1	(2) 7.7478 3	(3) 11.6217 4	(4) 15.4956 5	(5) 19.3695 6	(6) 23.2434 8
Urine Specimen - Routine (1.7673)	(1) 1.7673 .5	(2) 3.5346 1	(3) 5.3019 2			
Urine Specimen - Clean Catch/Foley Catheter (2.0660)	(1) 2.0660 1	(2) 4.1320 1	(3) 6.1980 2			
Vaginal/Pelvic Examination (5.6741)	(1) 5.6741 2	(2) 11.3482 4				
Perineal Care (2.3750)	(1) 2.3750 1	(2) 4.7500 2	(3) 7.1250 2	(6) 14.2500 5	(9) 21.3750 7	(12) 28.5000 10
Changing Perineal Pad (.7891)	(1) .7891 .5	(2) 1.5782 .5	(3) 2.3673 1	(6) 4.7346 2	(9) 7.1019 2	(12) 9.4692 3
Douche (1.8565)	(1) 1.8565 .5	(2) 3.7130 1	(3) 5.5695 2			
Perineal Suture Care Instruction (2.6457)	(1) 2.6457 1	(2) 5.2914 2	(3) 7.9371 3	(4) 10.5828 4	(5) 13.2285 4	(6) 15.8742 5

APPENDIX B

Medical/Surgical Patient Classification Instrument

a. Patient's Hospital Card

MEDICAL/SURGICAL PATIENT CLASSIFICATION INSTRUMENT

TOTAL PCIS Points WEIGHTED SCORE (Points) CATEGORY (Circle One)

1 - 39 1
40 - 79 2
80 - 159 3
160 - 239 4
240 - 499 5

b. DATE: _____

c. RATER'S NAME: _____

HYGIENE

	FREQUENCY	1	2	3
Bathing, Complete	SCORE	7	13	20
Bathing, Assist with Back & Legs		4		
Bathing, Utensils Provided		1		

	1	2	3
Sitting Shower/Shower with Assistance/ Tub Bath	6	12	17
AM Care.	2		
AM Care, Partial/Utensils Provided	1		

	1	2	3	6	9	12
Oral Hygiene	1	2	3	6	10	13
Skin Care/Back Rub	1	2	3	7	10	13
PM Care.	4					
Shaving.	2					
Shampoo.	3					

	1	2	3	4	5	6
Occupied Bed	3	6	10	13	16	19
Unoccupied Bed	2	4	6	8	10	12

	1	2	3	6	9	12
Changing Bed Linen Protector/Chux. . . . .	.5	1	1	2	3	4

PCIS .
13-15 16

NUTRITION/ELIMINATION

	FREQUENCY	1	3	6	9	12	24
Fluid/Snack	SCORE	.5	1	2	3	4	7
Feeding.		1	2	3			
		5	11	16			
Serving Meal Tray, Preparation Required . .		1	2	3			
Serving Meal Tray, No Preparation Required		.5	.5	.5			
Special Feeding - Nasogastric/Gastrostomy. .		1	2	3	6	9	12
		1	2	4	7	11	15
Special Feeding- Hyperalimentation/Intravenous		1	2	3	4	5	6
		2	4	6	8	10	12
Measuring/Recording Intake		1	3	6	9	12	24
		.5	1	2	3	3	7
Measuring/Recording Output - Urine/Liquid		1	2	3	4	5	6
Feces/Vomitus/Drainage Bottles, All Types.		.5	1	2	3	5	9
Giving a Bedpan.		1	2	3	6	9	12
		1	2	3	5	8	10
Giving a Urinal. . . . .		.5	1	2	4	6	8
Incontinent Care		2	5	7	14	21	29

PCIS .
17-19 20

MOBILITY/EXERCISE/SAFETY:

	FREQUENCY	1	3	6	9	12	24
Changing Patient's Position in Bed	SCORE	1	2	4	6	9	17
Adjusting Position of Bed. . . . .		.5	1	1	2	3	6
Adjusting Restraint . . . . .		.5	1	3	4	5	10
Exercise - Active/Passive.		1	2	3	6	9	12
		2	4	7	13	20	26
Mobility - Bed to Stretcher/Bed to Chair/ Ambulating First Time.		2	3	5	10	15	20
Mobility - Assistance While Walking/ Bedside Commode.		1	2	4	7	11	15
Mobility - Up to Floor/Sitting on Side of Bed		.5	1	2	4	5	7
Turning Frame, All types		3	6	9	18	27	36
Adjusting Siderail		4	8	12	24	36	48
		.5	1	1	3	4	6

PCIS .
21-23 24

MEDICATION

	FREQUENCY	2	3	6	12	18	24
Oral	SCORE	.5	1	2	3	5	6
Intramuscular.		1	2	3	4	5	6
		.5	1	1	2	2	2
Topical. . . . .		.5	1	1	2	2	2
Sublingual . . . . .		.5	.5	.5	.5	1	1
Subcutaneous . . . . .		.5	.5	1	1	2	2
Suppository - Rectal/Vaginal . . . . .		.5	1	1	2	2	3

PCIS .
25-27 28

SKIN

	FREQUENCY	1	2	3	6	9	12
Application of K-Pad/Heat Lamp	SCORE	.5	1	2	3	5	6
Decubitus Care/Soaking Hands/Cold Compress . .		3	6	9	18	25	35
		1	2	3	4	6	9
Small Dressing Change, <4"x8" /Soaking Feet/ Suture-Skin Clip Removal, <15		2	4	6	8	13	19
Large Dressing Change, ≥4"x8"/Wound Irrigation Reinforcing Dressing		4	8	12	16	24	36
		1	2	4	5	7	11
		1	2	3	4	5	6
Wound Culture/Hot Compress		1	2	3	3	4	5
Sitz Bath/Surgical Prep, Local		4	7	11	14	18	22
Suture-Skin Clip Removal, ≥15		5	10	14			
Surgical Prep, 3-Way		6					
Air Floatation/Alternating Pressure Mattress .		2					
		6	9	12	18	24	48
Isolation, Gowning & Gloving		3	4	6	9	12	23

PCIS .
49-51 . 52

SKELETAL/NEUROLOGICAL/EENT

	FREQUENCY	1	2	3	4	5	6
Pin/Head Tongs Care.	SCORE	2	5	7	9	11	14
		1	3	6	9	12	24
Circulation Check. . . . .		.5	1	1	2	3	5
Cast Care. . . . .		.5	1	2	3	4	9
Ice Pack . . . . .		.5	1	2	2	3	6
		1	2	3	6	9	12
Extremity Traction - Application		1	3	4	8	12	17
Extremity Traction - Adjust.		1	2	3	5	8	10
Extremity Elevation. . . . .		.5	.5	1	2	3	4
Eye Care . . . . .		.5	1	2	4	5	7
		1	2	3	4	5	6
Instillation of Drops - Eye/Ear/Nose . . . . .		.5	.5	.5	1	1	1
Culture - Sputum		1	2	2			
Culture - Nose/Throat. . . . .		.5	.5				

PCIS .
53-55 . 56

GASTROINTESTINAL

	FREQUENCY	1	2	3	6	9	12
Nasogastric Tube - Irrigation.	SCORE	.5	1	2	3	5	6
Nasogastric Tube - Instillation.		1	2	2	5	7	10

	1	2	3	4	5	6
Nasogastric Tube - Insertion	3	5	8	11	13	16
Nasogastric Tube - Removal . . . . .	.5	1				

	1	2	3
Enema - Cleansing.	2	3	5
Enema - Retention . . . . .	.5	1	
Colostomy Irrigation	8		
Fecal Impaction Assessment/Removal	1		

	1	2	3	4	5	6
Dressing Change, Colostomy/Ileostomy/ Ileoconduit	3	5	8	11	14	16

PCIS .
37-39 40

RESPIRATORY

	FREQUENCY	1	3	6	9	12	24
Oxygen Administration.	SCORE	.5	1	2	3	4	8

	1	2	3	6	9	12
Cough & Deep Breathe	1	2	2	5	7	9
Chest Pulmonary Therapy - Frappage with Postural Drainage.	1	2	4	7	11	15
Blow Bottles/Incentive Spirometer.	1	2	3	6	10	13
IPPB Treatment	3	5	8	16	24	32
Suctioning - Oral. . . . .	.5	1	2	3	5	7
Suctioning - Tracheostomy/Naso-Tracheal/ Endotracheal	1	2	3	7	10	14
Tracheostomy Care - Cleaning Cannula/ Dressing Change.	2	4	6	12	19	25
Positioning for X-Ray.	1	3	4			
Chest Tube - Insertion	9	18				
Chest Tube - Care.	4	8				
Chest Tube - Changing Bottles.	3	6				
Chest Tube - Removal	2	4				

PCIS .
41-43 44

CARDIOVASCULAR/TEMPERATURE REGULATION

	FREQUENCY	1	2	3	6	9	12
Venipuncture - Blood Sample.	SCORE	1	2	3	7	11	12
Arterial Puncture - Blood Gases.		2	4	5			
Venipuncture - Blood Culture		2	3	5			

	3	6	9	12	18	24
IV Infusion - Flow Rate.	1	2	2	3	5	6

	1	3	6	12	18	24
IV Infusion - IV Push/Piggy-Back Medication/ Changing IV Bottle . . . . .	.5	2	4	7	11	14

	1	2	3	4	5	6
IV Infusion - Initiating/IV Catheter Care. . .	3	6	10	13	16	19
IV Infusion - Infusion Pump Setup/ IV Termination.	1	2	3	5	6	7
IV Infusion - Platelets/Plasma/Blood	1	2	3	4	5	7
Elastic Stockings/Ace Bandage.	1	2	3			
Hypothermia/Hyperthermia Treatment	2					

PCIS .
45-47 48

VITAL SIGNS/ASSESSMENT/DIAGNOSTIC TESTS

	FREQUENCY					
	1	3	6	9	12	24
Blood Pressure, Manual SCORE	.5	1	2	3	4	8
Oral Temperature, Pulse, & Respirations. . .	.5	1	3	4	5	10
Pulse - Radial/Brachial/Apical/Pedal/ Femoral/Popliteal . . . . .	.5	1	2	3	4	8
Respirations . . . . .	.5	.5	1	2	3	5
Temperature - Oral/Rectal/Axillary . . . . .	.5	1	2	4	5	10
Rhythm Strip/Monitor . . . . .	.5	1	2	3	3	7
Adjusting Cardiac Monitor/Connecting Leads/ Reset Alarm. . . . .	.5	1	2	3	4	8
Pulmonary/Bowel Assessment . . . . .	.5	2	3	5	6	13
Pupil Reflexes . . . . .	.5	.5	1	2	3	5
Mental Alertness . . . . .	.5	1	2	3	4	
Orientation. . . . .	.5	1	2	3	4	8
Sensory Discrimination/Motor or Sensory Test	.5	1	3	4	5	10
Monitor Leads Application/Exchange	1	2	4	6		

	1	2	3	4	5	6
Heart Sounds Assessment. . . . .	.5	1	1	2	2	3
12 Lead ECG/Rhythm Strip - ECG Machine . . .	.5	6	9	12	15	18
Ambulatory Weight. . . . .	.5	1				
Bed Scale Weight	2	4				

	1	2	3	4	6	12
Urine Testing - Protein/Specific Gravity . .	.5	.5	1	1	1	3
Urine Testing - Sugar and Acetone. . . . .	.5	1	2	2	4	7
Guaiac Testing/Collection of Feces Sample. .	.5	1	1	2	3	6

	1	2	3	4	5	6
Situational Observation.	9	19	28	38	47	57

PCIS .
29-31 32

PSYCHOLOGICAL/PATIENT TEACHING

	FREQUENCY					
	1	2	3	6	9	12
Explanation of Procedures and Tests. . . SCORE	.5	1	2	3	5	7
Orientation to Clinical Unit	2	3	5			
Answering Patient's Question	3	6	12	18	24	48
Visiting with Patient/Purposeful Interaction .	1	2	4	6	8	16
	2	4	8	13	17	34
Teaching - Disease/Condition Related . .	1	2	3	6	9	12
	2	4	6	12	18	25
Teaching - Diagnostic Test /Urine Testing. .	1	2	3	4	5	6
Teaching - Dietary Explanation . . . . .	.5	1	1	2	2	2
Teaching - Blow Bottles/Incentive Spirometer .	1	2	3	4	5	6
Teaching - Dressing Change	1	2	4	5	6	7
Teaching - Ileostomy/Ileoconduit Care. . . .	2	4	6			
Teaching - Preoperative/Diabetic/Insulin	4	9	13			
Administration/Colostomy Care.	3	6				
Teaching - Medication Administration	7					

PCIS .
33-35 36

UROLOGICAL/GYNECOLOGICAL

	FREQUENCY	1	2	3	4	6	9
Condom Catheter Application.	SCORE	1	2	3	4	6	10
Catheterization - Foley.		3	5	8			
		1	2	3	4	5	6
Catheterization - Straight.		2	4	6	9	11	13
Foley Catheter Care/Foley Catheter Removal . .		1	3	4	5	6	8
Urine Specimen - Routine . . . . .		.5	1	2			
Urine Specimen - Clean Catch/Foley Catheter. .		1	1	2			
Vaginal/Pelvic Examination		2	4				
		1	2	3	6	9	12
Perineal Care.		1	2	2	5	7	10
Changing Perineal Pad. . . . .		.5	.5	1	2	2	3
Douche . . . . .		.5	1	2			
		1	2	3	4	5	6
Perineal Suture Care/Instruction		1	2	3	4	4	5

PCIS .
57-59 60

Locate required nursing activity on the Medical/Surgical Nursing Activities Tasking Document and calculate total points based on the weighted score provided. (Specify activity(s) and Total Score(s)).

THERAPEUTIC ACTIVITIES/MODALITIES (OTHER)

Nursing Activity	Frequency Rate	X	Score	=	Sub-Total
_____	_____	X	_____	=	_____
_____	_____	X	_____	=	_____
_____	_____	X	_____	=	_____

PCIS .
61-63 64

APPENDIX C

Medical/Surgical Patient Classification Instrument
Instructional Information

MEDICAL/SURGICAL PATIENT CLASSIFICATION INSTRUMENT

INSTRUCTIONAL INFORMATION

1. Demographic Information:

a. Stamp the Medical/Surgical Patient Classification Instrument with the patient's Hospital Card in the space provided.

b. Record the date of the data collection period. Note that the rater completes this form at the end of the 24-hour period.

c. Record the rater's name in the appropriate blank.

d. Utilize the keypunch spaces 1 through 12 to collect data which best meets the requirements for your medical treatment facility. This demographic data could include the following:

- (1) Age of Patient
- (2) Sex of Patient
- (3) Day of the Week
- (4) SI or VSI Status
- (5) Clinical Service

2. The Medical/Surgical Patient Classification Instrument is an objective factor evaluation designed rating instrument. Extensive clinical observation combined with time and frequency studies were undertaken to identify those direct nursing care activities which most influence the total patient care requirements. These groupings of nursing activities, listed below, are considered to be Patient Care Indicators. Each nursing activity is operationally defined in the attached Tasking Document. The sum of the total points within each patient care indicator will become the Patient Care Indicator Score (PCIS).

- a. Hygiene
- b. Nutrition/Elimination
- c. Mobility/Exercise/Safety
- d. Medication
- e. Vital Signs/Assessment/Diagnostic Tests
- f. Psychological/Patient Teaching
- g. Gastrointestinal

- h. Respiratory
- i. Cardiovascular/Temperature Regulation
- j. Skin
- k. Skeletal/Neurological
- l. Urological/Gynecological
- m. Therapeutic Activities/Modalities (Includes "Other" nursing activities)

3. The patient classification instrument is simple in that the professional nurse needs only to rate those nursing activities which are appropriate for the patient being rated. The nursing activities scored on the instrument must have been performed by nursing personnel or assistance provided to other staff members performing the activity. If the patient performs self-care activities, then score only those nursing activities performed by nursing personnel. Each patient needs only one rating for each 24-hour period. The rating of each patient must be completed at the end of the 24-hour period and must reflect the nursing care requirements for the preceding 24 hours. The normal rating period will be 0700 to 0700 hours, however, patients who are hospitalized less than 24 hours must also be rated. The ratings of these patients must be reflective of the time period that the patient was present within the hospital system.

4. The actual rating of each patient is accomplished by selecting the frequency rate for each nursing activity that was required during the rating period. The rating of the patient on the classification instrument is then accomplished by selecting the frequency rate from the options provided on the instrument. Select the frequency rate for each nursing activity that best meets the care requirements for the patient being rated. Each frequency rate has a corresponding point value (weighted score) as denoted in the blocks below each frequency rate.

EXAMPLE:

		FREQUENCY	1	2	3	6	9	12
Oral Hygiene	SCORE		1	2	3	6	10	13

This nursing activity with a frequency of "9" will receive a score of "10". Circle the appropriate score. After circling the score for each appropriate nursing activity, sum the scores within each Patient Care Indicator. Record this point value in the space provided as indicated in the following example:

EXAMPLE:

MEDICATION		FREQUENCY SCORE					
		2	3	6	12	18	24
Oral	SCORE	.5	1	2	3	5	6
Intramuscular . . . . .		.5	1	1	2	2	2
Topical . . . . .		.5	1	1	2	2	2
Sublingual . . . . .		.5	.5	.5	.5	1	1
Subcutaneous . . . . .		.5	.5	1	1	2	2
Suppository - Rectal/Vaginal . . . . .		.5	1	1	2	2	3
PCIS		25-27		28			

This Patient Care Indicator (Medication) consists of "3" oral, "1" intramuscular, and "6" topical for a total of "3.5" points.

5. If the patient requires a nursing activity that is not included on the Medical/Surgical Patient Classification Instrument, this additional procedure should be followed:

Locate the Nursing Activity Tasking Document (pages 19 thru 23) and obtain the score (points) for that activity. This point value is for a frequency of one, therefore, you must then multiply that figure by the appropriate frequency rate.

EXAMPLE:

UROLOGICAL

URINARY BLADDER TRAINING: Upon arrival at bedside, clamp/unclamp catheter, record time and urine output if appropriate. .5

Should the patient require eight urinary bladder training procedures during the 24-hour period, multiply the frequency of "8" times the score of ".5". Indicate the activity(s) selected and the total point value clearly on the instrument (i.e., Urinary Bladder training = 4).

6. The total PCIS points (Sum of the Patient Care Indicator Scores) determines the patient's Category of Care. Indicate the Total PCIS Points and circle the appropriate Category on page 1 of the Medical/Surgical Patient Classification Instrument.

EXAMPLE:

TOTAL PCIS Points	WEIGHTED SCORE (Points)	CATEGORY (Circle One)
	1 - 39	1
79.5	40 - 79	2
	80 - 159	3
	160 - 239	4
	240 - 499	5

ROUND DOWN THE FRACTIONS: For example, anything less than "80" TOTAL PCIS Points will have the weighted SCORE of "79" and will remain Category "2".

7. The Medical/Surgical Patient Classification-Tabulation Form was developed for the recording of the Patient Care Indicator Scores (PCISs). These scores are to be recorded on this tabulation form along with the patient's name and age.

MEDICAL/SURGICAL PATIENT CLASSIFICATION TABULATION FORM			TOTAL POINTS	HOURS OF CARE	CATEGORY OF CARE	NO. OF CASES
			1 - 39	<1 - 1	1	
			40 - 79	2 - 3	2	
			80 - 159	4 - 7	3	
			160 - 239	8 - 11	4	
			240 - 499	12 - 24	5	

			Patient Care Indicator Scores													Total PCIS Score	Category of Care
Nursing Unit	Date	Nurse's Signature	Hygiene	Nutrition/ Elimination	Mobility/ Exercise/Safety	Medication	Vital Signs/ Assessment/ Diagnostic Test	Psychological/ Patient Teaching	Gastrointestinal	Respiratory	Cardiovascular/ Temperature Regulation	Skin	Skeletal/ Neurological/EENT	Urological/ Gynecological	Other/Therapeutic Activities/ Modalities		
Bed No.	Age	Name of Patient															

MEDICAL/SURGICAL NURSING ACTIVITIES TASKING DOCUMENT

Each operational definition includes; (1) Identify and screen the patient; (2) Explain the procedure to the patient; (3) Raise, lower, or adjust the bed before and after the nursing activity; and (4) Clean and straighten area.

HYGIENE:

SCORE

BATHING, COMPLETE: Place equipment at bedside; remove pajamas, bathe face, chest, abdomen and extremities; change water, bathe back, buttocks and perineal area; replace pajamas; and remove equipment from area.

7

BATHING, ASSIST WITH BACK & LEGS: Place equipment at bedside; remove pajamas, allow for patient bathing as if in attendance; change water; then bathe back and lower extremities; replace pajamas and remove equipment from area.

4

BATHING, UTENSILS PROVIDED: Place equipment at bedside, allow time for patient to bathe and change pajamas; then remove equipment from area.

1

SITTING SHOWER/SHOWER WITH ASSISTANCE: Upon arrival in the shower room, assist patient in undressing, into shower, with bath and hair shampoo, assist in redressing, and back into the wheelchair. (Must remain with patient and provide assistance during the entire procedure.)

6

OR

TUB BATH: Upon arrival in bathroom, assist patient in undressing, into bathtub, with bath and assist in redressing; then back into the wheelchair (nursing personnel must be in constant attendance).

AM CARE: Place equipment at bedside, assist patient with bathing face, hands, and brushing teeth; then remove equipment from area.

2

AM CARE, PARTIAL: Place equipment at bedside, prepare bath water, put toothpaste on tooth brush; and remove equipment from area when patient has completed AM Care.

1

OR

AM CARE, UTENSILS PROVIDED: Place equipment at bedside, and then remove equipment from area when patient finishes AM Care.

ORAL HYGIENE: Place equipment at bedside, turn patient to his/her side, cleanse gums, teeth and mouth with applicators; then remove equipment from area.

1

SKIN CARE: Place equipment at bedside, cleanse and dry areas for special care, apply lotion, and then remove equipment from area. (Buttocks, hips, shoulders, heels.)

1

OR

BACK RUB: Place equipment at patient's bedside, remove pajama top, turn patient to expose back, rub back with lotion, replace pajama top, and then remove equipment from area.

	<u>SCORE</u>
<u>PM CARE:</u> Place equipment at bedside; bathe face and hands, brush teeth, and rub back; tighten and straighten bed linens; then remove equipment from area,	4
<u>SHAVING:</u> Place equipment at bedside; wet and lather face/or use an electric razor and shave face; then remove equipment from area,	2
<u>SHAMPOO:</u> Place equipment at bedside; position patient, wet hair and apply shampoo, lather and rinse, dry hair with towel, comb and brush hair; and then remove equipment from area.	3
<u>OCCUPIED BED:</u> Place linen at bedside; turn patient on side, roll linen to one side of bed, replace with clean linen, turn patient to freshly made side of bed, remove soiled linen and complete bed making; then remove soiled linen from bed.	3
<u>UNOCCUPIED BED:</u> Place linen at bedside, remove soiled linen, place bottom sheet on mattress, then place on top sheet; change pillow cases; remove soiled linen from area.	2
<u>CHANGING BED LINEN PROTECTOR/CHUX:</u> Upon arrival at bedside, position patient, remove soiled chux, place clean chux under patient, straighten bed; then remove used chux from area.	.5

NUTRITION/ELIMINATION:

<u>FLUID:</u> Place fluids at bedside, place plastic drinking tube in liquid, give liquid to patient, then remove drinking cup and/or place within reach at patient's bedside.	.5
OR	
<u>SNACK:</u> Place snack at bedside and, if required, prepare food for eating.	
<u>FEEDING:</u> Place meal tray at bedside; place towel or napkin as bib; prepare the food, feed patient slowly with appropriate utensils; then remove tray from area.	5
<u>SERVING MEAL TRAY, PREPARATION REQUIRED:</u> Place tray at bedside, prepare food and utensils, and prepare towel or napkin as bib.	1
<u>SERVING MEAL TRAY, NO PREPARATION REQUIRED:</u> Place tray at bedside.	.5
<u>SPECIAL FEEDING - NASOGASTRIC:</u> Place feeding at bedside, unclamp tube, assess placement of tube, administer tube feeding, flush tube with water, clamp tube, record, and then remove feeding equipment from area.	1
OR	
<u>SPECIAL FEEDING -GASTROSTOMY:</u> Place feeding at bedside, uncoil and unclamp tube, administer feeding, flush tube with water, clamp tube, recoil and replace tube, and then remove feeding equipment from area.	

SPECIAL FEEDING - HYPERALIMENTATION, INTRAVENOUS: Determine calibration of infusion equipment. Place hyperalimentation fluids at bedside, exchange filter and tubing, establish scheduled flow rate, record, and then remove equipment from area.

2

OR

SPECIAL FEEDING - NASOGASTRIC, CONTINUOUS FEEDING WITH GASTRIC FEEDING EQUIPMENT: Place equipment at bedside; connect to feeding tube/nasogastric tube, adjust flow rate, record on intake and output record; then remove equipment from area.

OR

SPECIAL FEEDING - NASOGASTRIC, CONTINUOUS WITH INFUSION PUMP:

Place equipment at bedside; remove and/or position feeding bottle, connect to feeding tube, set-up through flow rate adjuster of equipment, establish flow rate, record on Intake and Output Record; then remove equipment from area.

MEASURING AND RECORDING INTAKE: Place calibrated cylinder/container at bedside; measure or calculate fluids, record amount on Intake and Output Record; then remove equipment from area.

.5

MEASURING AND RECORDING OUTPUT - URINE: Place calibrated cylinder at bedside; measure or calculate volume, record amount on Intake and Output Record; then remove equipment from area.

.5

OR

MEASURING AND RECORDING OUTPUT - LIQUID FECES: Remove bedpan from patient's bedside; measure feces in calibrated cylinder, record amount on Intake and Output Record.

OR

MEASURING AND RECORDING OUTPUT - VOMITUS: Remove emesis from patient's bedside, measure vomitus in calibrated cylinder, record amount on Intake and Output Record.

OR

MEASURING AND RECORDING OUTPUT - DRAINAGE BOTTLES/ALL TYPES: Place calibrated cylinder at bedside, pour contents from drainage bottle into calibrated cylinder, measure or calculate volume, replace drainage bottle, record amount on Intake and Output Record, and then remove equipment from area.

GIVING A BEDPAN: Place bedpan at bedside, place patient on bedpan, provide toilet tissue, remove patient from bedpan, cover bedpan, and remove from area.

1

GIVING A URINAL: Place urinal at patient's bedside, remove cover, adjust patient's pajamas for placement of urinal, remove urinal from patient, replace cover; then remove urinal from area.

.5

INCONTINENT CARE: Place equipment at patient's bedside, bathe buttocks, perineum and thighs; change bedding; then remove equipment and soiled linen from area.

2

MOBILITY/EXERCISE/SAFETY;

- CHANGING PATIENT'S POSITION IN BED: Remove support pillows, reposition patient; apply support pillows. 1
- ADJUST POSITION OF BED: Raise, lower or adjust position of bed. .5
- OR
- FOWLERS/TRENDELENBERG POSITION: Upon arrival at bedside, position bed in either Fowlers or Trendelenberg position, assess comfort of patient in this position, and then depart from area.
- ADJUSTING RESTRAINT: Upon arrival at bedside, replace or apply restraints to upper and/or lower extremities, and then depart from area. .5
- EXERCISE - ACTIVE: Supervise the patient as he/she actively performs the prescribed exercise program. 2
- OR
- EXERCISE - PASSIVE: Manually moving patient's extremities through the prescribed exercise program.
- MOBILITY - BED TO STRETCHER: Place stretcher at bedside, transfer patient to stretcher, fasten safety straps or adjust side rail, remove stretcher from bedside (or reverse procedure). 2
- OR
- MOBILITY - BED TO CHAIR: Position chair/wheelchair at bedside, assist patient into sitting position, slowly bring patient into an upright standing position; then assist into chair/or reverse process.
- OR
- MOBILITY - AMBULATING FIRST TIME: Assist patient into sitting position on side of bed; then into upright standing position; walk with patient; then assist back into bed.
- MOBILITY - ASSISTANCE WHILE WALKING: Assist patient into a sitting position on side of bed, then into an upright standing position, then with ambulation, and then back into bed. 1
- OR
- MOBILITY - BEDSIDE COMMODE: Position commode chair next to bedside, assist patient into sitting position, slowly bring patient into an upright standing position, assist patient onto commode chair, and then assist patient back into bed.
- MOBILITY - BED TO FLOOR: Assist patient into sitting position on side of bed, then slowly bring patient into an upright position; then assist back into bed. .5
- OR
- MOBILITY - SITTING ON SIDE OF BED: Assist patient into sitting position on side of bed; then assist patient back into supine position.

SCORE

TURNING FRAME, ALL TYPES: Remove or secure support pillows and devices, place and secure restraining straps, unlock frame, turn frame according to specifications, lock frame, remove restraining straps, adjust pillows and support devices. 3

ADJUSTING SIDERAIL: Changing position of siderail, i.e., up, down, or removal. .5

MEDICATION:

ORAL: Upon arrival at bedside, obtain a glass of water and administer the oral medication. .5

INTRAMUSCULAR: Place equipment at bedside, locate site for injection, administer medication, and then remove equipment from area. .5

TOPICAL: Place equipment at bedside, locate and expose site for topical application of medication, apply medication, and then remove equipment from area. .5

SUBLINGUAL: Place equipment at bedside, place medication under patient's tongue; then remove equipment from area. .5

SUBCUTANEOUS: Place equipment at bedside, locate site for injection, administer medication, and then remove equipment from area. .5

SUPPOSITORY, RECTAL/VAGINAL: Place equipment at bedside, prepare and administer suppository; then remove equipment from area. .5

VITAL SIGNS/ASSESSMENT/DIAGNOSTIC TESTS:

BLOOD PRESSURE, MANUAL: Place equipment at bedside, place cuff around extremity, position stethoscope, measure blood pressure, remove cuff, record results; remove equipment from area. .5

ORAL TEMPERATURE, PULSE AND RESPIRATIONS: Place equipment at bedside, position temperature probe or thermometer. Place fingers over radial artery pulse and count rate. Count respiratory rate while fingers are placed over radial artery pulse. Remove fingers from radial artery pulse rate, record results of measurements, and then remove equipment from area. .5

PULSE - RADIAL/BRACHIAL: Place fingers over radial pulse and count rate, brachial pulse, and count rate. Remove fingers from pulse area and record results. .5

OR

PULSE - APICAL: Place equipment at bedside, place stethoscope over apex of heart and count rate, remove stethoscope, record pulse rate, and then remove equipment from area.

OR

PULSE - PEDAL/FEMORAL/POPITEAL: Place fingers on the dorsalis pedis artery pulse, femoral or popiteal pulse, and count rate. Remove fingers from area and record results.

RESPIRATIONS: Count respiratory rate, and/or count and calculate rate, and then record. ,5

TEMPERATURE - ORAL, ELECTRONIC/MERCURY: Place equipment at bedside, place probe or thermometer under tongue, measure temperature, remove temperature probe or thermometer, record and then remove equipment from area. ,5

OR

TEMPERATURE - RECTAL, ELECTRONIC/MERCURY: Place equipment at bedside, adjust clothing, insert temperature probe or thermometer in anus, measure temperature, remove temperature probe or thermometer, record, and then remove equipment from area.

OR

TEMPERATURE - AXILLARY, ELECTRONIC/MERCURY: Place equipment at bedside, place temperature probe or thermometer in axillary area, measure temperature, remove temperature probe or thermometer, record and then remove equipment from area.

RHYTHM STRIP/MONITOR: Obtain 20 second strip, record name, date and time, then file for future use. .5

ADJUSTING CARDIAC MONITOR/CONNECTING LEADS/RESET ALARM: Upon arrival at the bedside, adjust cardiac monitor, connect leads or reset the alarm; then depart the area. .5

PULMONARY ASSESSMENT: Upon arrival initiate assessment by auscultation of the lungs, and/or percussion of the chest wall over the involved areas. Assess symmetry of chest and determine if respiratory movement is abdominal or thoracic. .5

OR

BOWEL SOUND ASSESSMENT: Upon arrival at bedside, utilize a stethoscope to assess status of bowel sounds, then remove equipment from area.

PUPIL REFLEXES: Place equipment at bedside, adjust room lighting, assess pupillary reflexes with flashlight and remove equipment from area. .5

MENTAL ALERTNESS: Upon arrival at bedside, make inquiries within the framework of interviewing that will give information about the patient's orientation, memory, intellectual performance, and judgment; record results. .5

ORIENTATION: Upon arrival at bedside, make inquiries within the framework of interviewing that will give information about patient's orientation for time, place and person, and then record results. .5

SENSORY DISCRIMINATION: The utilization of those approaches which will indicate that the examiner is screening for pain, vibration, light touch, and stereognosis intact, and then record results. .5

OR

MOTOR/SENSORY TESTING: Upon arrival at the bedside, assess extremities for sensation awareness and muscle strength.

SCORE

MONITOR LEADS APPLICATION/EXCHANGE: Place equipment at bedside, exchange leads/or apply new leads, and then remove equipment from area. 1

HEART SOUNDS ASSESSMENT: Place stethoscope at bedside, arrange pajamas for visual access of chest, assess and record findings; remove stethoscope from area. .5

12 LEAD ECG: Place equipment at bedside, connect leads to patient and obtain ECG. Record name, date and time on ECG. Remove leads and clean skin, then remove equipment from area. 3

OR

RHYTHM STRIP - ECG MACHINE: Place equipment at bedside, prepare equipment for use, apply limb leads, obtain 20 second strip, record name, date and time, remove limb leads; remove equipment from area.

AMBULATORY WEIGHT: Place equipment at bedside, assist patient onto the scales, balance scales, read and record weight reading, assist patient off the scales, and then remove equipment from area. .5

BED SCALE WEIGHT: Place equipment at bedside, assist patient onto the scales, read and record weight reading, assist patient in getting off the scales, and then remove equipment from area. 2

URINE TESTING - PROTEIN: Upon arrival at bedside, collect urine sample, utilizing test strip assess for albumin, compare test strip against standard, read and record results; remove used equipment from area. .5

OR

URINE TESTING - SPECIFIC GRAVITY: Place equipment at bedside, collect urine sample and utilizing a urometer, measure specific gravity, record results, and then remove equipment from area.

URINE TESTING - SUGAR & ACETONE: Place equipment at bedside, collect urine sample, measure sugar and acetone, record results, then remove equipment from area. .5

GUAIAAC TESTING - FECES/VOMITUS/GI DRAINAGE: Upon obtaining sample, test for guaiac, record results, and then remove equipment from area. .5

OR

COLLECTION OF FECES SAMPLE: Upon obtaining a feces sample, place sample in collection container, label, and then remove from area.

SITUATIONAL OBSERVATION: Assignment of one member of the nursing team to observe and provide nursing care to the patient during a specific activity. Observation required only during the specific activity. This might include, but is not limited to, transport within or without the hospital when the patient is not stable enough to be left without nursing support. 9

PSYCHOLOGICAL/PATIENT TEACHING:

EXPLANATION OF PROCEDURES AND TESTS: Instructing patient on what he/she can expect from procedure/test, what the health care personnel will be doing during the procedure/test, and why such procedure/test is being done. .5

	<u>SCORE</u>
<u>ORIENTATION TO CLINICAL UNIT:</u> Instructing on the use of the nurse's call system, the hospital bed, and the layout of the physical facility.	2
<u>ANSWERING PATIENT'S QUESTION:</u> Time spent in answering patient's questions or in response to the patient call system.	.5
<u>VISITING WITH PATIENT/PURPOSEFUL INTERACTION:</u> Time spent at patient's bedside without providing any direct physical care to patient which is not in response to patient call system or patient questions.	.5
<u>TEACHING - DISEASE/CONDITION RELATED:</u> Upon arrival at bedside, provide instruction on the nature and scope of the disease process, special care requirements, limitations and/or restrictions related to disease illness.	2
<u>TEACHING - DIAGNOSTIC TEST:</u> Upon arrival at the bedside, provide info on the purpose and requirements for the diagnostic test.	.5
OR	
<u>TEACHING - URINE TESTING:</u> Place equipment at bedside, provide instructions on the purpose and technique for the urine testing.	
<u>TEACHING - DIETARY EXPLANATION:</u> Upon arrival at bedside, provide instruction on dietary requirements/restrictions.	1
<u>TEACHING - BLOW BOTTLES/INCENTIVE SPIROMETER:</u> Place equipment at bedside, instruct patient on the purpose and use of equipment.	1
<u>TEACHING - DRESSING CHANGE:</u> Upon arrival at bedside, provide instruction on technique of dressing change, skin care and how to recognize abnormal conditions related to disease/injury.	2
<u>TEACHING - ILEOSTOMY/ILEOCONDUIT CARE:</u> Upon arrival at bedside, provide instruction on purpose, equipment and care of the ileostomy or ileoconduit.	4
<u>TEACHING - PREOPERATIVE INSTRUCTION:</u> Upon arrival at bedside, provide instruction on preoperative and postoperative requirements. (Skin prep, cough and deep breathe, ankle exercise and position change.)	3
OR	
<u>TEACHING - DIABETIC:</u> Upon arrival at bedside, provide information on the disease process and care related to this process. (Signs and symptoms on insulin lack/overdosage, foot care, rotation of injection sites, exercise program, storage of medication, and maintenance of equipment.) (Insulin administration should be measured under teaching insulin administration.)	
OR	
<u>TEACHING - INSULIN ADMINISTRATION:</u> Upon arrival at bedside, provide information on dosage, types of insulin, syringe utilization technique, care of equipment, rotation of sites, and specific drug related information.	
OR	
<u>TEACHING - COLOSTOMY CARE:</u> Upon arrival at bedside, provide instructions on the purpose, equipment and technique of colostomy irrigation, and colostomy bag care.	
<u>TEACHING - MEDICATION ADMINISTRATION:</u> Upon arrival at bedside, provide instruction on dosage, route, and specific drug related information.	7

GASTROINTESTINAL:

NASOGASTRIC TUBE - IRRIGATION: Place irrigation solution at bedside, unclamp or disconnect tube, irrigate tubing with asepto syringe, reclamp or reconnect tubing; then remove equipment from area. .5

NASOGASTRIC TUBE - INSTILLATION: Place medication, and/or normal saline at bedside, unclamp or disconnect tube, instill solution with asepto syringe, reclamp or reconnect tubing; then remove equipment from area. 1

NASOGASTRIC TUBE - INSERTION: Place equipment at bedside, secure towel around patient's neck, give patient glass of water, instruct patient on how to swallow tube, lubricate tube, insert tube, assess for placement, tape in position, then remove equipment from area/or when non-responsive omit glass of water and instructions. 3

NASOGASTRIC TUBE - REMOVAL: Place towel around patient's neck, position patient, remove tape, clamp tube and remove tubing, and then remove equipment from area. .5

ENEMA - CLEANSING: Place equipment at bedside, position patient, lubricate tubing, insert rectal tube, administer solution; then remove equipment from area. 2

ENEMA - RETENTION: Place equipment at bedside, position patient, administer solution; then remove equipment from area. .5

COLOSTOMY - IRRIGATION: Place equipment at bedside, remove colostomy bag/dressing, administer irrigation solution, allow for return of fluid and feces, cleanse skin and stoma, reapply colostomy bag/dressing; then remove equipment from area. 8

FECAL IMPACTION ASSESSMENT/REMOVAL: Upon arrival at bedside, position patient, put on rubber gloves, assess for fecal impaction and then manually break-up fecal mass; then remove used equipment from area. 1

DRESSING CHANGE - COLOSTOMY: Place equipment at bedside, remove soiled dressing, cleanse skin and stoma, apply clean dressing, and then remove equipment from area. 3

OR

DRESSING CHANGE - ILEOSTOMY/ILEOCONDUIT: Place equipment at bedside, remove ileostomy bag or dressing, cleanse skin and stoma area, replace ileostomy bag or dressing, and remove equipment from area.

RESPIRATORY:

OXYGEN ADMINISTRATION - RESPIRATOR: Upon arrival at bedside assess and/or regulate oxygen and ventilator pressures, assess all tubing for patency and collection of fluids within tubing, assess fluid level in water vapor container, and then assess proper position of alarms. .5

OR

OXYGEN ADMINISTRATION - PRONGS: Place equipment at bedside, fit nasal prongs and adjust headband, regulate oxygen rate; evaluate patient's adjustment to oxygen and equipment.

OR

OXYGEN ADMINISTRATION - MASK: Place equipment at bedside, turn on oxygen, fit the mask over the mouth and nose, adjust headband, evaluate fit and patient's adjustment to the equipment, and regulate oxygen flow rate.

OR

OXYGEN ADMINISTRATION - NASAL: Place equipment at bedside, turn on oxygen, lubricate and insert nasal catheter, secure with tape; evaluate and regulate oxygen flow rate. ,5

OR

OXYGEN ADMINISTRATION - MIST WITH COLLAR/FACE TENT: Place equipment at bedside, turn on oxygen, position equipment; then secure, evaluate, and regulate oxygen flow rate.

COUGH AND DEEP BREATHE: Upon arrival at bedside, have patient cough and deep breathe, if cough productive then dispose of sputum. 1

CHEST PULMONARY THERAPY - FRAPPAGE WITH POSTURAL DRAINAGE: Upon arrival at bedside, position patient, initiate treatment by auscultation of lung fields. Perform percussion to each involved segment followed by vibration. 1

BLOW BOTTLES: Place equipment at bedside, assist with placement of bottles, have patient perform procedure; then locate equipment at bedside for next treatment. 1

OR

INCENTIVE SPIROMETER: Place spirometer at bedside, assist patient during the procedure to determine proper usage of spirometer, and then remove or replace to storage area at bedside.

IPPB TREATMENT: Place equipment in position of use, assist patient during the treatment, and replace equipment after use. 3

SUCTIONING - ORAL: Place equipment or set-up equipment at bedside, suction oral cavity with suction catheter/or oral suction tip, flush catheter before and after each aspiration, replace used equipment, and remove used equipment from area. .5

SUCTIONING - TRACHEOSTOMY: Set-up equipment, put on sterile gloves, suction and flush catheter before and after each aspiration, replace used equipment, and remove used equipment from area. 1

OR

SUCTIONING - NASO-TRACHEAL: Set-up equipment at bedside, put on sterile gloves, pass nasal catheter and suction, flush catheter before and after each aspiration, replace used equipment; remove used equipment from area.

OR

SUCTIONING - ENDOTRACHEAL: Set-up sterile equipment at bedside, put on sterile gloves, suction through endotracheal tube, flush catheter before and after each use, bag breathe between each aspiration, remove gloves, replace used equipment, and then remove used equipment from area.

TRACHEOSTOMY - CLEANING CANNULA: Place of utilize equipment at bedside, complete tracheostomy suction, remove, clean and replace inner tube, and then remove soiled equipment and replace with clean equipment, 2

OR

TRACHEOSTOMY - DRESSING CHANGE: Place equipment at bedside, remove soiled dressing, cleanse skin, replace dry dressing, change tracheostomy ties as indicated, and then remove soiled equipment from area.

	<u>SCORE</u>
<u>POSITIONING FOR X-RAY:</u> Upon arrival at bedside, assist with positioning of x-ray film; then assist with removal of exposed film.	1
<u>CHEST TUBE - INSERTION:</u> Place all equipment at bedside, assist physician with insertion of chest tube, prepare water-sealed drainage bottles, tape all connections and drainage bottles; then remove equipment from area.	9
<u>CHEST TUBE - CARE:</u> Set-up equipment at bedside, remove dressing around chest tube, cleanse skin, replace dressing, tape securely, and then remove used equipment from area.	4
<u>CHEST TUBE - CHANGING BOTTLES:</u> Place prepared chest tube bottles at bedside, clamp chest tube, change drainage tube and bottles, secure drainage bottles and tops with tape, unclamp chest tube, and then remove used equipment from area.	3
<u>CHEST TUBE - REMOVAL:</u> Place equipment at bedside, assist physician with removal of chest tube, apply pressure dressing; then remove equipment from area.	2

CARDIOVASCULAR/TEMPERATURE REGULATION:

<u>VENIPUNCTURE - BLOOD SAMPLE:</u> Place equipment at bedside. Apply tourniquet to extremity, cleanse site, perform venipuncture and withdraw blood sample, and then apply pressure to puncture site. Apply labels on blood tubes and remove equipment from area.	1
<u>ARTERIAL PUNCTURE - BLOOD GASES:</u> Place equipment at bedside, locate arterial puncture site, perform puncture and draw blood, and then place sample on ice. Apply pressure to puncture site; then label sample and remove equipment from area.	2
<u>VENIPUNCTURE - BLOOD CULTURE:</u> Place equipment at bedside, apply tourniquet to extremity, clean site, perform venipuncture and withdraw blood sample, and then apply pressure to puncture site. Apply labels on blood culture bottle and remove equipment from area.	2
<u>INTRAVENOUS INFUSION - FLOW RATE:</u> Upon arrival calculate and adjust flow rate as specified.	.5
<u>INTRAVENOUS INFUSION - IV PUSH MEDICATION:</u> Place equipment at bedside, select site for injection of solution utilizing existing system, administer IV solution, and remove equipment from area.	.5
OR	
<u>INTRAVENOUS INFUSION - PIGGY-BACK MEDICATION:</u> Place equipment at bedside, select site for administration of solution utilizing existing systems, record on Intake and Output record, and remove equipment from area.	
OR	
<u>INTRAVENOUS INFUSION - CHANGING IV BOTTLE:</u> Place equipment at bedside, remove used IV container and replace with new IV container, calculate and regulate flow rate, record on I&O record, and remove equipment from area.	

SCORE

INTRAVENOUS INFUSION - INITIATING: Place equipment at bedside, apply tourniquet to extremity, cleanse site, perform venipuncture and connect IV tubing, apply ointment and dressing, and tape securely. Calculate and regulate flow rate, record on Intake and Output record, and remove equipment from area. 3

OR

INTRAVENOUS INFUSION - IV CATHETER CARE: Place equipment at bedside, remove dressing from IV catheter site, cleanse skin, apply ointment, replace dressing and then date, time and initial the dressing, change IV tubing, and remove equipment from area.

INTRAVENOUS INFUSION - INFUSION PUMP SETUP: Place equipment at bedside, set-up IV tubing and adjust flow rate dial. Record on I&O record and remove used equipment from area. 1

OR

INTRAVENOUS OR ARTERIAL LINE - TERMINATION: Place equipment at bedside, remove dressing and terminate IV or arterial catheter/needle, apply pressure to site, and record on I&O if appropriate. Remove equipment from area.

INTRAVENOUS INFUSION - PLATELETS/PLASMA: Place equipment at bedside, connect to present intravenous system, record on I&O record; and remove used equipment from area. 1

OR

INTRAVENOUS INFUSION - BLOOD: Place equipment at bedside, assure correct transfusion, etc., connect to present intravenous system, record on I&O record, and remove equipment from area.

ELASTIC STOCKINGS: Place stockings at bedside. Expose lower extremities, and then put elastic stockings on lower extremities. 1

OR

ACE BANDAGE: Place equipment at bedside, wrap extremity securely with ace bandage and secure in place with tape or metal hooks.

HYPOTHERMIA/HYPERTHERMIA TREATMENT: Place equipment at bedside, apply blankets, assess status of equipment. Insert rectal temperature probe for monitoring, and then remove unused equipment from area. 2

SKIN:

APPLICATION OF K-PAD: Upon arrival at bedside, apply K-Pad to prescribed area, then depart from area. .5

OR

HEAT LAMP: Place or position lamp at bedside, expose site, and apply heat lamp.

DECUBITUS CARE: Place or position equipment at bedside, cleanse skin, apply heat lamp and/or expose to light. (If dressing is utilized, then count as dressing change.) 3

OR

SOAKING HAND: Place equipment at bedside, soak hand in solution basin, remove and towel dry hand, and then remove equipment from area.

OR

COLD COMPRESS: Place equipment at bedside, apply cold compress to site and then remove equipment from area. 3

SMALL DRESSING CHANGE, < 4"x 8": Place equipment at bedside, remove soiled dressing, cleanse skin, apply dressing to site; remove equipment from site. 2

OR

SOAKING FOOT: Place equipment at bedside, soak feet in solution basin, remove and towel dry feet, and remove equipment from area.

OR

SUTURE/SKIN CLIP REMOVAL, < 15: Place equipment at bedside, remove dressing if required, remove sutures or skin clips, then remove equipment from area.

LARGE DRESSING CHANGE, > 4"x 8": Place equipment at bedside, remove soiled dressing, cleanse skin, apply dressing to site; remove equipment from area. 4

OR

WOUND IRRIGATION: Place equipment at bedside, remove soiled dressing, irrigate and cleanse site, apply dressing and then remove equipment from area.

REINFORCING DRESSING: Place equipment at bedside, apply dressing to present dressing for reinforcement, and then remove equipment from area. 1

WOUND CULTURE: Place equipment at bedside, remove soiled dressing, obtain culture from site, label culture, apply new dressing, and then remove equipment from area. 1

OR

HOT COMPRESS: Place equipment at bedside, apply hot compress to site, and then remove equipment from area.

SITZ BATH: Prepare sitz bath equipment, assist patient into sitz bath tub, assist patient from the tub and towel dry, and then assist patient into bed. 4

OR

SURGICAL PREP, LOCAL: Place equipment at bedside, prepare skin for prep, shave area specified, and then remove used equipment from area.

SUTURE/SKIN CLIP REMOVAL, > 15: Place equipment at bedside, remove dressing if required, remove sutures, and then remove equipment from area. 5

SURGICAL PREP, 3-WAY: Place equipment at bedside, prepare skin for prep, shave area specified, and then remove used equipment from bedside. Instruct patient to shower with surgical soap three times. 6

AIR FLOATATION/ALTERNATING PRESSURE MATTRESS: Place equipment at bedside, apply air floatation or alternating pressure mattress to hospital bed. (Turn patient as appropriate if application is made with patient in the bed.) Remove soiled linens/equipment from area. 2

ISOLATION, GOWNING & GLOVING: Upon arrival at isolation area, wash hands, put on isolation gown, mask and gloves, or when departing the isolation area, remove isolation gown, mask and gloves; then wash hands. .5

SKELETAL/NEUROLOGICAL/EENT:

PIN CARE: Place equipment at bedside, cleanse pin site; then remove used equipment from area. (Clean not sterile procedure.) 2

OR

HEAD TONGS CARE: Place equipment at bedside, cleanse area around head tongs, and then remove equipment from area.

CIRCULATION CHECK: Upon arrival at bedside check extremity for swelling, numbness, and tingling, evaluate temperature and color of the skin, and then assess the patient's ability to move the part. .5

CAST CARE: Upon arrival at bedside, assess for pain, swelling, numbness, tingling, coldness & bluish discoloration of the skin. Evaluate the patient's ability to move the part, and then assess the temperature of the cast and the skin area around the cast. .5

ICE PACK: Place ice bag at bedside, remove old ice bag and replace with new ice bag, secure ice bag in place; then remove equipment from area. .5

EXTREMITY TRACTION - APPLICATION: Place equipment at bedside, apply non-invasive type traction to extremity, apply weights, and then remove unused equipment from area. 1

EXTREMITY TRACTION - ADJUST: Upon arrival at bedside, assess the position of the weights and the alignment of the traction equipment. 1

EXTREMITY ELEVATION: Place equipment at bedside, elevate extremity through use of pillows, bed adjustments and/or sling attachments. .5

EYE CARE: Place equipment at bedside, cleanse eyes and apply solution/ointment as prescribed. Apply eye patch and then remove equipment from area. .5

INSTILLATION OF DROPS - EYE: Upon arrival at bedside, position patient, instill eye drops, and then remove equipment from area. .5

OR

INSTILLATION OF DROPS - EAR: upon arrival at bedside, position patient, instill ear drops, and then remove equipment from area.

OR

INSTILLATION OF DROPS - NOSE: Upon arrival at bedside, position patient, instill nose drops, and then remove equipment from area..

CULTURE - SPUTUM: Place equipment at bedside, position patient, have patient cough to obtain sputum, apply label to sputum specimen, and then remove equipment from area. 1

OR

SCORE

CULTURE - NOSE: Place equipment at bedside, position patient, obtain nose culture, label culture, and remove equipment from area. .5

CULTURE - THROAT: Place equipment at bedside, position patient, obtain throat culture, label culture, and remove equipment from area,

UROLOGICAL /GYNECOLOGICAL:

CONDOM CATHETER APPLICATION: Upon arrival at bedside, apply condom catheter, connect to a urinary drainage bag; then depart from area. 1

CATHETERIZATION - FOLEY: Place equipment at bedside, prepare patient and insert Foley Catheter, inflate balloon, tape catheter in position, connect to urinary drainage bag; then remove used equipment from area. 3

CATHETERIZATION - STRAIGHT: Place equipment at bedside, prepare patient and insert catheter, empty bladder and remove straight catheter; then remove used equipment from area. 2

FOLEY CATHETER CARE: Place equipment at bedside, cleanse area around catheter, apply ointment, and then remove used equipment from area. 1

OR

FOLEY CATHETER REMOVAL: Place equipment at bedside, expose catheter and drainage system, deflate Foley balloon and remove Foley catheter. Measure urine and record on I&O record; remove used equipment from area.

URINE SPECIMEN - ROUTINE: Place equipment at bedside, instruct patient on how to collect specimen, label specimen, and then remove specimen from area. .5

URINE SPECIMEN - CLEAN CATCH/FOLEY: Place equipment at bedside, instruct patient on how to collect specimen, or collect sample from Foley catheter, label specimen, and then remove specimen from area. 1

VAGINAL/PELVIC EXAMINATION: Assist patient onto examination table, position patient, set-up equipment and assist physician with the procedure; then assist patient in getting off the examination table. 2

PERINEAL CARE: Place equipment at bedside, prepare and cleanse perineal area (use bedpan with treatment solution/or bathe area); then remove equipment from area. 1

CHANGING PERINEAL PAD: Place supplies at bedside, assess amount of bleeding, change perineal pad; then remove used supplies from area. .5

DOUCHE: Place equipment at bedside, position patient on bedpan, administer douching solution, remove bedpan from under patient; then remove equipment from area. .5

PERINEAL SUTURE CARE: Cleanse area with antiseptic solution, irrigate with water, dry suture area, and apply heat lamp to suture line, 1

OR

PERINEAL SUTURE CARE INSTRUCTION: Place equipment at bedside, instruct patient on technique of perineal care, i.e., cleanse area with antiseptic solution, irrigate with water, dry suture area. Apply heat lamp to suture line.

OTHER NURSING ACTIVITIES WHICH MAY BE UTILIZED TO DETERMINE CATEGORY OF CARE;

HYGIENE:

- NAIL CARE: Place equipment at bedside, wash hands/feet and nails, trim and clean finger/toe nails, remove equipment from area. 1
- CHANGING BOTTOM SHEET: Place linen at bedside, remove bottom sheet, replace with clean sheet, straighten top sheet; then remove soiled linen from area. 1
- CHANGING TOP SHEET: Place linen at bedside, remove top sheet, replace with clean sheet; then remove soiled linen from area. .5

NUTRITION/ELIMINATION:

- OUTPUT WEIGHT, DIAPER/BED LINENS: Upon the completion of the procedure for diaper change/bed linen change, remove items to be weighed, weigh on weight scales, and then record results. .5

VITAL SIGNS/ASSESSMENT/DIAGNOSTIC TESTS:

- PULSE - DOPPLER: Place equipment at bedside, place sensor over pulse area, assess and record pulse rate; then remove equipment from area. 1
- ABDOMINAL GIRTH MEASUREMENT: Upon arrival at bedside, expose abdominal area, measure girth, record and then depart from area. 1
- EXTREMITY CIRCUMFERENCE MEASUREMENT: Upon arrival at bedside, place tape measure around the extremity/extremities and assess measurement; then record results. .5
- CENTRAL VENOUS PRESSURE, MANUAL: Setup equipment for measurement of pressure, position patient and assess sternal angle, measure pressure, restore equipment to original position, and record results. 1
- MONITOR READING - BLOOD PRESSURE/HEART RATE/PULMONARY ARTERY PRESSURE/CENTRAL VENOUS PRESSURE: Upon arrival at bedside, assess and record findings. .5
- RHYTHM STRIP MEASUREMENTS: Upon obtaining the rhythm strip, measure P-R interval, S-T segment, and assess for arrhythmic pattern; then record results. .5
- VITAL CAPACITY: Place equipment at bedside. Utilizing the spirometer determine the respiration reserve volume, the tidal volume and the expiratory reserve volume. Calculate and record results and then remove equipment from area. 2
- BONE MARROW ASPIRATION: Place equipment at bedside, assist physician with procedure, and then remove equipment from area. 5
- LUMBAR PUNCTURE: Place equipment at bedside, assist physician with procedure, and then remove equipment from area. 7

SCORE

LIVER BIOPSY: Place equipment at bedside, measure baseline vital signs, assist physician with the procedure, and then remove equipment from area. (All post-procedure vital signs will be counted as routine and separate from the procedure.) 5

PROCTOSCOPY: Upon arrival at patient's area, place equipment, support patient during the procedure; then remove equipment from area. 7

ENDOSCOPY: Upon arrival at patient's area, place equipment, assess baseline vital signs (BP, P.R&T). Support patient during the procedure, repeat vital signs; then remove equipment from area. 7

LAVAGE: Place equipment at bedside, secure towel around patient's neck, insert stomach tube, assess placement, lavage gastric contents, remove tube, and then remove equipment from area. 7

PARACENTESIS: Place equipment at bedside, measure vital signs, prepare patient and tray for procedure, assist physician and support patient during the procedure, measure vital signs, and then remove equipment from area. 8

THORACENTESIS: Place equipment at bedside, obtain vital signs, assist physician and support patient during the procedure, repeat vital signs, measure and record aspiration fluids, and then remove equipment from area. 9

BRONCHOSCOPY: Place equipment at bedside, assist physician with the procedure, then remove equipment from area. 7

HEMATOCRIT: Upon obtaining the blood sample, process, assess and record the results. 1

PSYCHOLOGICAL/PATIENT TEACHING:

TEACHING - PERINEAL SUTURE CARE: Place equipment at bedside, instruct patient on technique of perineal care, i.e., cleanse area with antiseptic solution, irrigate with water, dry suture area. Then apply heat lamp to suture line. 1

TEACHING - BREAST FEEDING: Provide instructions on the technique of breast feeding; observe mother during the feeding process to assess proper technique. 4

TEACHING - BOTTLE FEEDING: Upon arrival at bedside, provide instructions on the technique of bottle feeding; observe mother during the feeding process to assess proper technique. 3

TEACHING - BREAST CARE: Upon arrival at bedside, instruct patient on how to cleanse area around nipple, the need for wearing a support bra, and how to recognize minor signs and symptoms of problems that may occur with breast feeding. 1

GASTROINTESTINAL:

RECTAL TUBE INSERTION: Place equipment at bedside, insert rectal tube, connect to drainage bag; then remove used equipment from area. 1

RECTAL TUBE REMOVAL: Place equipment at bedside, remove rectal tube and drainage bag; then remove used equipment from area. 1

RESPIRATORY:

RESPIRATORY RESUSCITATION: Place equipment at bedside. Check all equipment, assist physician with insertion of endotracheal/tracheostomy tube, bag breathe as indicated, connect respirator; then remove equipment from area. 11

INTUBATION: Place equipment at bedside, assist physician during the intubation process, tape endotracheal tube in place and remove equipment from area. 6

EXTUBATION: Place equipment at bedside, assist physician with removal of endotracheal tube; then remove equipment from area. 1

CARDIOVASCULAR/TEMPERATURE REGULATION:

INTRAVENOUS/ARTERIAL LINE - BLOOD SAMPLE: Place equipment at bedside, clear system, obtain blood sample through stopcock, flush system, label samples, and then remove equipment from bedside. 1

SURGICAL INTRAVENOUS INITIATION, CUT DOWN: Place equipment at bedside, assist physician with the procedure as required, connect to intravenous line set-up, assess status of intravenous line; then remove equipment from area. 15

ARTERIAL LINE - ARTERIAL LINE SET-UP: Place equipment at bedside, set-up transducer tray, IV solution and cardiac monitor. Assist physician with insertion of arterial catheter. Calibrate the cardiac monitor, and measure the transducer current with a mercury sphygmomanometer. Remove equipment from area. 6

ARTERIAL LINE - ARTERIAL LINE SETUP: Place equipment at bedside, assist physician with the procedure as required, connect to arterial line set-up, assess status of arterial line; then remove equipment from area. 15

ARTERIAL LINE - TRANSDUCER EXCHANGE: Place equipment at bedside, set-up transducer tray and IV solution, calibrate the cardiac monitor, and measure the transducer current with a mercury sphygmomanometer. Remove equipment from area. 5

ARTERIAL LINE - SWAN GANZ CATHETER SETUP: Place equipment at bedside, set-up transducer tray, IV solution and cardiac monitor. Assist physician with the insertion of the Swan-Ganz catheter. Calibrate the cardiac monitor and then measure the transducer current with a mercury sphygmomanometer. Measure and record pulmonary artery pressure and/or PAEDP wedge. Remove equipment from area. 11

SWAN GANZ CATHETER - INITIATION: Place equipment at bedside, assist physician with the procedure as required, connect to arterial line set-up, assess status of arterial infusion system; then remove equipment from area. 14

SWAN GANZ CATHETER - REMOVAL: Place equipment at bedside, assist physician with the removal of the Swan Ganz catheter, apply dressing; then remove equipment from area. 2

EXTERNAL PACEMAKER: Place equipment at bedside, assess vital signs (BP, P&R), assist physician with the procedure, repeat the vital signs (BP, P&R); then remove equipment from area. 3

CARDIOVERSION: Place equipment at bedside, assess vital signs (BP, P&R), assist physician with the procedure as required, repeat vital signs (BP, P&R); then remove equipment from area. 8

CARDIOPULMONARY RESUSCITATION: Upon arrival at bedside, perform any or all aspects of cardiopulmonary resuscitation. 21

SKIN:

DEATH CARE: Place equipment at bedside, prepare patient and cover with shroud. 8

SKELETAL/NEUROLOGICAL/EENT:

FOOT BOARD: Place equipment at bedside, position foot board into place and then align and position the extremities. .5

BED CRADLE: Place equipment at bedside and position bed cradle over patient. .5

SEIZURE CARE: Upon arrival in the patient's area, place padded tongue blade in position, and support patient during the seizure. 2

UROLOGICAL/GYNECOLOGICAL:

URINARY BLADDER TRAINING: Upon arrival at bedside, clamp/unclamp catheter, record time and urine output if appropriate. .5

BLADDER IRRIGATION: Place equipment at bedside, set up equipment and irrigate bladder; then remove equipment from area. 1

PERITONEAL DIALYSIS - INITIATION: Place equipment at bedside, assist physician with procedure as required, then remove equipment from area. 11

PERITONEAL DIALYSIS - EXCHANGE OF DIALYSIS SOLUTIONS: Place equipment at bedside, administer dialysis solution, measure output of dialysis solution, record results; then remove equipment from area. 7

PERITONEAL DIALYSIS - REMOVING DIALYSIS CATHETER: Place equipment at bedside, assist physician with the removal of the dialysis catheter, apply dressing to area; then remove equipment from area. 2

DILITATION AND CURETTAGE: Upon arrival in minor surgery room, position patient on the examination table, set-up equipment and assist physician with the procedure. After completion of the procedure, apply perineal pad; then assist patient on stretcher. 10

FUNDUS MASSAGE: Upon arrival at bedside, expose patient's lower abdominal area, massage fundus and assess height of uterus; then record. .5

CHANGING PERINEAL PAD: Place supplies at bedside, assess amount of bleeding, change perineal pads; then remove used supplies from area. .5

SCORE

PERINEAL SUTURE CARE: Cleanse area with antiseptic solution, irrigate with water, dry suture area, and apply heat lamp to suture line. 1

POST PARTUM ASSESSMENT: Upon arrival at bedside complete the following: 1
(a) Initiate assessment of breast by inspection and palpation of each breast, assess for contour, engorgement, tenderness, nodules, venous patterns and color; (b) Initiate assessment of uterus by inspection and palpation, assess for involution, tone, contour, and location; (c) Initiate bladder assessment by eliciting feedback, inspection and palpation, assess for distention, frequency of urination and pain on urination; (d) Initiate episiotomy assessment by assisting patient into a lateral position and by inspection of perineal/rectal area, assess for inflammation, infection and hemorrhoids; (e) Initiate assessment of bowel function by eliciting feedback for bowel movements and adequacy of diet and; (f) Initiate assessment for Homan's Sign by assisting patient to supine position and then press on patient's knee and flex patient's foot.

APPENDIX D
Medical/Surgical Patient Classification
Tabulation Form

TOTAL POINTS	HOURS OF CARE	CATEGORY OF CARE	NO. OF CASES
-----------------	------------------	---------------------	-----------------

80-159	4-7
160-239	8-11
240-499	12-24

54321

Patient Care Indicator Scores	
1	2
3	4
5	6
7	8
9	10
11	12
13	14
15	16
17	18
19	20
21	22
23	24
25	26
27	28
29	30
31	32
33	34
35	36
37	38
39	40
41	42
43	44
45	46
47	48
49	50
51	52
53	54
55	56
57	58
59	60
61	62
63	64
65	66
67	68
69	70
71	72
73	74
75	76
77	78
79	80
81	82
83	84
85	86
87	88
89	90
91	92
93	94
95	96
97	98
99	100

Date _____
Rater's _____
Signature _____

Bed	No.	Age	Name of Patient
-----	-----	-----	-----------------

Nursing Unit		Date	Rate's Signature	Bed No.	Age	Name of Patient
						Hygiene
						Nutrition/ Elimination
						Mobility/ Exercise/Safety
						Medication
						Vital Signs/ Assessment/ Diagnostic Test
						Psychological/ Patient Teaching
						Gastrointestinal
						Respiratory
						Cardiovascular/ Temperature Regulation
						Skin
						Skeletal/ Neurological/EENT
						Urological/ Gynecological
						Other/Therapeutic Activities/ Modalities
						Total PCIS Score
						Category of Care

Medical/Surgical

Bed	No.	Age	Name of Patient
-----	-----	-----	-----------------

Continuation Sheet:												
Medical/Surgical												
Bed No.	Age	Name of Patient										
			Hygiene									
			Nutrition/ Elimination									
			Mobility/ Exercise/Safety									
			Medication									
			Vital Signs/ Assessment/ Diagnostic Test									
			Psychological/ Patient Teaching									
			Gastrointestinal									
			Respiratory									
			Cardiovascular/ Temperature Regulation									
			Skin									
			Skeletal/Neuro- logical/EENT									
			Urological/ Gynecological									
			Other/Therapeu- tic Activities/ Modalities									
			Total PCIS Score									
			Category of Care									

APPENDIX E

Methodology for Determining Care Provider Mix
for Medical/Surgical

NURSING CARE HOUR STANDARDS
METHODOLOGY FOR DETERMINING CARE PROVIDER MIX
MEDICAL/SURGICAL

A. The Percentage Table for Care Provider Mix is a product of Phase II of the Nursing Care Hour Standards Study. During this phase the study team obtained 37,000 on-site measurements at nine medical treatment facilities. These data results were utilized in the development of the personnel percentage tables. This percentage table is designed only for use with the Medical/Surgical Patient Classification Tabulation Form.

B. To compute the number of hours of care by provider groups the following steps must be completed.

1. To determine total hours for each patient care indicator complete the next 3 steps.

a. Using the scores from the Medical/Surgical Patient Classification Tabulation Form (AHS 091-4 test), add the PCISs down the patient care indicator column. The total gives the total PCIS for that patient care indicator.

b. Multiply that PCIS for the column by 3 to obtain total minutes for the patient care indicator column.

c. Divide the total minutes for each patient care indicator column by 60 to find total hours for each patient care indicator.

MEDICAL/SURGICAL PATIENT CLASSIFICATION TABULATION FORM	TOTAL POINTS	HOURS OF CARE	CATEGORY OF CARE	NO. OF CASES
	1 - 39	<1 - 1	1	1
	40 - 79	2 - 3	2	5
	80 - 159	4 - 7	3	3
	160 - 239	8 - 11	4	0
	240 - 499	12 - 24	5	1

			Patient Care Indicator Scores														Total PCIS Score	Category of Care
Nursing Unit	MEDICAL/SURGICAL		Hygiene	Nutrition/ Elimination	Mobility/ Exercise/Safety	Medication	Vital Signs/ Assessment/ Diagnostic Test	Psychological/ Patient Teaching	Gastrointestinal	Respiratory	Cardiovascular/ Temperature Regulation	Skin	Skeletal/ Neurological/EENT	Urological/ Gynecological	Other/Therapeutic Activities/ Modalities			
Date	0700 5 NOV - 0700 6 NOV 80	Rater's Signature	CPT JONES															
Bed No.	Age	Name of Patient																
1	75	Patient 1	11.0	21.0	15.0	3.0	7.0	10.0	0	0	0	0	1.0	0	0	68.0	2	
2	59	Patient 2	25.0	36.0	17.0	2.0	12.0	6.0	0	8.0	7.0	0	0	0	0	113.0	3	
3	22	Patient 3	25.0	24.0	11.0	3.0	15.0	8.0	0	15.0	23.0	12.0	7.0	3.0	0	146.0	3	
4	20	Patient 4	15.0	4.0	13.0	0	1.5	7.5	0	11.0	0	0	8.0	0.5	0	60.5	2	
5	20	Patient 5	10.0	2.0	7.0	0	7.0	17.0	0	0	10.0	4.0	0	4.0	0	61.0	2	
6	64	Patient 6	21.0	34.0	18.0	1.5	24.0	9.0	2.0	11.0	17.0	0	0	0	0	137.5	3	
7	56	Patient 7	46.0	48.0	12.0	4.0	32.5	21.0	10.0	9.0	37.0	36.0	0	0	0	255.5	5	
8	21	Patient 8	9.0	0.5	0	1.0	4.5	6.0	0	0	0	6.0	0	0	0	27.0	1	
9	62	Patient 9	17.0	22.0	0	2.0	10.0	3.0	0	4.0	0	0	0	0	0	58.0	2	
10	27	Patient 10	9.0	4.5	0	2.0	40.0	8.0	0	3.0	1.0	1.0	0	0	0	69.5	2	
		TOTAL POINTS	188.0	196.0	93.0	18.5	153.5	95.5	12.0	61.0	95.0	59.0	16.0	7.5	0	995.0		
		TOTAL MINUTES	564.0	588.0	279.0	55.5	460.5	286.5	36.0	183.0	285.0	177.0	48.0	22.5	0	2985.0		
		TOTAL HOURS	9.40	9.80	4.65	.93	7.68	4.78	.60	3.05	4.75	2.95	.80	.38	0	49.75		

AHS Form 091-4 (Test)
6 October 1980

EXAMPLE: Patient Care Indicator - Hygiene

- Add column down for Total Points = 188 points
- Multiply total points by 3 - $188 \times 3 = 564$ minutes
- Divide total minutes by 60 - $564 \div 60 = 9.40$ hours

2. To determine hours of care provided by each provider group utilize the total hour score from each patient care indicator located on the Medical/Surgical Patient Classification Tabulation Form (AHS-091-4 Test) and the Medical/Surgical Percentage Table For Care Provider Mix which follows:

PERCENTAGE TABLE FOR CARE PROVIDER MIX

MEDICAL/SURGICAL

	PROFESSIONAL	TECHNICAL	PARAPROFESSIONAL
HYGIENE	15	61	24
NUTRITION/ ELIMINATION	25	55	20
MOBILITY/ EXERCISE/ SAFETY	26	53	21
MEDICATION	90	9	1
VITAL SIGNS/ ASSESSMENT/ DIAGNOSTIC TEST	30	47	23
PSYCHOLOGICAL/ PATIENT TEACHING	60	28	12
GASTROINTESTINAL	39	41	20
RESPIRATORY	29	56	15
CARDIOVASCULAR/ TEMPERATURE REGULATION	75	21	4
SKIN	23	55	22
SKELETAL/ NEUROLOGICAL/BENT	46	33	21
UROLOGICAL/ GYNECOLOGICAL	37	50	13
OTHER THERAPEUTIC ACTIVITIES/ MODALITIES	54	36	10

Professional =

Registered Professional
Nurses (ANC and DAC 7-13)

Technical =

Licensed Vocational/
Technical Nurses
(DAC 5-6, 91C10-40 and 91B40)

Paraprofessional =

Nursing Assistants
(DAC 3-4 and 91B10-30)

- Select the total hour score for each patient care indicator.
- Select the personnel percentage score for each patient care indicator.
- Multiply the total score for each patient care indicator by the appropriate percentage score.

EXAMPLE: Patient Care Indicator - Hygiene

- Total Hour Score = 9.40
- Personnel Percentage Score for Patient Care Indicator =
Professional 15%
Technical 61%
Paraprofessional 24%
- Multiply total score for PCIS by the Personnel Percentage Score =
 $15\% \times 9.40 = 1.41$ Hours by Professionals
 $61\% \times 9.40 = 5.73$ Hours by Technicians
 $24\% \times 9.40 = 2.26$ Hours by Paraprofessionals

3. To determine total hours of direct care provided by each provider group the following steps must be completed.

a. Add the rows across for the total hours by provider group. This will provide you the total number of hours of direct care by each provider group.

	Hygiene	Nutrition/ Elimination	Mobility/ Exercise/Safety	Medication	Vital Signs/ Assessment/ Diagnostic Test	Psychological/ Patient Teaching	Gastrointestinal	Respiratory	Cardiovascular/ Temperature Regulation	Skin	Skeletal/ Neurological/EENT	Urological/ Gynecological	Other/Therapeutic Activities/ Modalities	
TOTAL HOURS	9.40	9.80	4.65	.93	7.68	4.78	.60	3.05	4.75	2.95	.80	.38	0	
PROFESSIONAL	1.41	2.45	1.21	.84	2.30	2.87	.23	.88	3.56	.68	.37	.14	0	= 16.94
TECHNICAL	5.73	5.39	2.46	.08	3.61	1.34	.25	1.71	1.00	1.62	.26	.19	0	= 23.64
PARAPROFESSIONAL	2.26	1.96	.98	.01	1.77	.57	.12	.46	.19	.65	.17	.05	0	= 9.19

EXAMPLE:

Professional

$$1.41 + 2.45 + 1.21 + .84 + 2.30 + 2.87 + .23 + .88 + 3.56 + .68 + .37 + .14 = 16.94 \text{ TOTAL HOURS BY PROVIDER GROUP}$$

Technical

$$5.73 + 5.39 + 2.46 + .08 + 3.61 + 1.34 + .25 + 1.71 + 1.00 + 1.62 + .26 + .19 = 23.64 \text{ TOTAL HOURS BY PROVIDER GROUP}$$

Paraprofessional

$$2.26 + 1.96 + .98 + .01 + 1.77 + .57 + .12 + .46 + .19 + .65 + .17 + .05 = 9.19 \text{ TOTAL HOURS BY PROVIDER GROUP}$$

b. Divide the total hours for each provider group by 8 (hours/shift) to obtain number and mix of care providers required for direct care activities.

EXAMPLE:

$$\begin{aligned} 16.94 \div 8 &= 2.12 \text{ Professional mandays of direct care} \\ 23.64 \div 8 &= 2.96 \text{ Technical mandays of direct care} \\ 9.19 \div 8 &= 1.15 \text{ Paraprofessional mandays of direct care} \end{aligned}$$

4. The investigator recommends that quarterly computations of provider mix will be sufficient.

HCSD Report #81-009 (Part IV)

Nursing Care Hour Standards Study: Part IV
Obstetric Patient Classification Subsystem

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Final Report

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Nursing Care Hour Standards Study: Part IV Obstetric Patient Classification Subsystem

A. INTRODUCTION

Part IV Obstetric Patient Classification Subsystem addresses the development and testing of a multidimensional factor-evaluation designed patient classification subsystem for the obstetrical service. The approach undertaken was to differentiate those direct nursing care activities that were unique to the obstetrical service. Previously reported patient classification systems made the assumption that obstetrical nursing care activities could be measured with the medical/surgical patient classification instrument; however, our preliminary findings did not support this assumption. Therefore, it was determined if nursing managers are to make sound administrative decisions on staffing the obstetrical service, they must measure the appropriate nursing care activities and use the best measuring tool available. The best tool would be an acceptable reference standard, namely, the number of hours of nursing care required to meet safe essential patient care needs with the proper mix by skill level of care providers. The present study has attempted to develop and provide such a tool for the obstetrical service. The approach undertaken also considered the fact that time accountability is the principle commodity in accounting for human resource utilization.

B. OBJECTIVES

The two objectives for Part IV Obstetric Patient Classification Subsystem were:

1. To develop a factor-evaluation designed patient classification subsystem for the obstetrical service which would provide a better staffing mix based on quantified direct nursing care requirements.
2. To determine if the Obstetric Patient Classification Subsystem demonstrates validity and reliability.

C. OBSTETRIC PATIENT CLASSIFICATION SUBSYSTEM

The format and factor-evaluation design of the Obstetric Patient Classification Subsystem was devised to enable professional nurses in its use to ascertain direct nursing care requirement for inpatients. The Obstetric Patient Classification Subsystem was designed with five components: (1) patient classification instrument mathematical model; (2) patient classification instrument; (3) patient classification instrument instructional information; (4) patient classification tabulation form; and (5) methodology for determining care provider mix. The methodology for the development of each component will be discussed.

1. Obstetric Patient Classification Instrument Mathematical Model.

The obstetric patient classification instrument mathematical model (Appendix A) was designed for an automated or manual system. The design of the model delineates the direct nursing care activities, frequency rate for a 24-hour time frame, and the appropriate weighted score. The organization of the mathematical model displays all dimensions of direct patient care and all direct nursing care activities within each dimension labeled as patient care indicator.

If the primary purpose of the obstetric patient classification subsystem was to determine the need for direct nursing care resources, then the patient care indicators must represent those direct nursing care activities that have the greatest impact on nursing care time. The obstetric patient classification instrument was developed by utilizing those patient care indicators which were ascertained through timing and observational studies. The obstetric patient classification instrument mathematical model was designed with the following patient care indicators:

- a. Hygiene
- b. Nutrition/Elimination
- c. Mobility/Exercise/Safety
- d. Psychological/Patient Teaching
- e. Vital Signs/Assessment/Diagnostic Tests
- f. Medication
- g. Gastrointestinal
- h. Respiratory
- i. Cardiovascular
- j. Skin
- k. Skeletal/Urological/Gynecological
- l. Obstetrical

The obstetric patient classification instrument mathematical model clearly delineates those direct nursing care activities that are unique to the obstetrical patient. Therefore, the obstetric patient classification instrument mathematical model was designed to quantify the direct nursing requirements for the obstetric inpatient. The obstetric patient classification instrument mathematical model was developed utilizing the same criterion as the critical care and medical/surgical patient classification instrument mathematical models. Likewise, the weighted score for each direct nursing care activity was determined by selecting the best common denominator to fit the total number of direct nursing care activities included within the mathematical model. The weighted factor scale which follows was utilized in developing the obstetric patient classification instrument mathematical model: three minutes equals one point; two to three minutes equals one point; and less than two minutes equals 0.5 point. This point conversion scale allows for simple arithmetic summing to quantify the hours of direct nursing care required for obstetrical inpatients, and even if all of the direct nursing care activities were required for an obstetric patient the error rate would not exceed plus or minus thirty minutes.

2. Obstetric Patient Classification Instrument.

The obstetric patient classification instrument (Appendix B) was designed for factor evaluation. Extensive comparative analyses were conducted for the

determination of the patient care indicators which were considered to represent those direct nursing care activities that have the greatest impact on nursing care time. Based upon these findings thirteen patient care indicators were incorporated within the factor-evaluation designed instrument. Therefore, this type of design allows for the identification of direct nursing care activities for each patient care indicator.

The obstetric patient classification instrument was designed to provide a simple tool in which the professional nurse needs only to rate those direct nursing care activities which are appropriate for the patient being rated. The direct nursing care activities scored on the instrument must have been performed by nursing personnel or assistance provided to other staff members performing the activity. If the patient performs self-care activities, then only those direct nursing care activities performed by nursing personnel are scored. The system was designed so that each patient needs only one rating for each 24-hour rating period. The ratings are completed at the end of the 24-hour rating period and are reflective of the preceding 24-hour time frame. The normal rating period was 0700 to 0700 hours; however, patients who were hospitalized less than 24 hours were also rated. In those patients who were within the system less than 24 hours the ratings were reflective of the time period that the patient was present within the hospital system.

The obstetric patient classification instrument was designed to allow for the actual rating of each patient to be accomplished by selecting the frequency rate for each direct nursing care activity that was required during the rating period. Therefore, rating of the patient on the obstetric patient classification instrument was accomplished by selecting the frequency rate for the required direct nursing care activity from the options provided on the instrument. Moreover, the instrument was designed so that the frequency rate for each direct nursing care activity has a corresponding point value labeled as weighted score. The format for the obstetric patient classification instrument follows the same format as the obstetric patient classification instrument mathematical model. As was presented earlier, the patient care indicators were identified as those groupings of direct nursing care activities which most influence the total patient care requirements. Based upon the design of the obstetric patient classification instrument it is the total points within each patient care indicator that determines the patient care indicator score (PCIS). The sum of the patient care indicator scores determines the total points, hours of care, and category of care for the rated patient.

The obstetric patient classification instrument was developed with the following classification scheme as displayed in Table 1.

Table 1
Obstetric Patient Classification Scheme

Total Points	Hours of Care	Category of Care
1 - 39	< 1 thru 1	1
40 - 79	2 thru 3	2
80 - 159	4 thru 7	3
160 - 239	8 thru 11	4
240 - 499	12 thru 24	5

1

A unique feature considered in the development of the obstetric patient classification instrument is the option of including infrequently occurring direct nursing care activities which impact significantly on nursing workload, and can be included in the rating under "other therapeutic activities/modalities."

The obstetric patient classification instrument was designed to allow for collection of demographic information. The keypunch spaces one through twelve were provided for data collection which best meets the requirements of the medical treatment facility.

3. Obstetric Patient Classification Instrument Instructional Information.

The obstetric patient classification instrument instructional information component (Appendix C) was developed to provide adequate information for the user to consistently apply the same methodology for rating patients' direct care requirements. The organization of the operational definitions and weighted score for each direct nursing care activity follows the same format as the obstetric patient classification instrument mathematical model and the obstetric patient classification instrument components. To reduce the redundancy of the operational definitions provided, each direct nursing care activity also includes: (a) identify and screen the patient; (b) explain the procedure to the patient; (c) raise, lower, or adjust the bed before and after the nursing activity; and (d) clean and straighten area.

In utilizing the obstetric patient classification instrument instructional information component the score for each direct nursing care activity applies only to the Obstetric Patient Classification Subsystem for which it was designed. The obstetric patient classification instrument instructional information component provides the listing of those infrequently occurring direct nursing care activities which impact significantly on nursing workload, and each of these direct nursing care activities are included as additional direct nursing care activities that can be included in the rating under "other therapeutic activities/modalities." This list of direct nursing care activities is not all-inclusive, as the frequency with which some direct nursing care activities occurred was not sufficient to permit an accurate analysis or generation of a valid weighted score.

4. Obstetric Patient Classification Tabulation Form.

The obstetric patient classification tabulation form (Appendix D) was designed for the recording of summary data. After the assessment of direct nursing care requirements has been completed by the professional nurse, the unit clerk can use the obstetric patient classification tabulation form to record the patient care indicator scores for each patient. The instructions for recording of patient data are located within the obstetric patient classification instrument instructional information component. The data accumulated to this point provides the necessary information for determining category of care and the hours of care within each patient care indicator for the obstetrical unit.

The results from extensive data analyses were utilized to design the obstetric patient classification tabulation form. These analyses demonstrated that distribution of hours of care within each patient care indicator and not the category of care determines the mix by skill level of care providers required to meet the rated direct nursing care requirements for obstetric inpatients. It must be emphasized that both category of care and hours of care within each patient care indicator can determine man-hour requirements, but only the hours of care

within each patient care indicator can determine the best mix by skill level of care providers.

Since all medical treatment facilities do not have automated systems readily available, the obstetric patient classification tabulation form was designed to allow for manual computations, as well as keypunching of the patient care indicator scores. Lastly, the obstetric patient classification tabulation form was designed with the same format as the obstetric patient classification instrument mathematical model, obstetric patient classification instrument, and obstetric patient classification instrument instructional information components.

5. Methodology for Determining Care Provider Mix for Obstetrics.

The methodology for determining care provider mix for obstetrics (Appendix E) was developed for the purpose of providing the best mix by skill level of care providers. The diversity of direct nursing care activities requires a more complex mix of personnel; therefore, more sophisticated techniques are required to meet these demands. During the timing and observation studies the observers recorded the number and skill level of care providers for each direct nursing care activity. These data were utilized to establish personnel mix percentage scores for each direct nursing care activity. These personnel mix percentage scores were utilized in the development of the personnel percentage table for care providers for obstetrical patients. The percentage table for provider mix for obstetrics was developed by collapsing the personnel percentage scores for each direct nursing care activity within each patient care indicator. Table 2 displays the percentage table for care provider mix for obstetrics.

Table 2
Percentage Table for Care Provider Mix for Obstetrics

	Professional	Technical	Paraprofessional
Hygiene	15	61	24
Nutrition/Elimination	24	55	21
Mobility/Exercise/Safety	26	54	20
Psychological/Patient Teaching	60	28	12
Vital Signs/Assessment/ Diagnostic Tests	28	48	24
Medication	89	9	2
Gastrointestinal	40	39	21
Respiratory	37	47	16
Cardiovascular	74	21	5
Skin	25	52	23
Skeletal/Urological/ Gynecological	33	47	20
Obstetrical	65	25	10
Other Therapeutic Activities/ Modalities	42	43	15

The mix by skill level of care providers can easily be determined by utilizing the summary data from the obstetric patient classification tabulation form and the percentage table for care provider mix for obstetrics. This approach differs significantly from previous patient classification systems which match category of care with mix of personnel. Present findings demonstrate that the hours of care within each patient care indicator was the determinant for the mix by skill level of care providers and not the category of care. It must be noted that patient classification systems that match category of care with mix of personnel make the major assumption that all patients in the same category of care have the same direct nursing care requirements; hence, the same mix of personnel can meet those care requirements. However, the present findings do not support this assumption.

It is important to note that the percentage table for care provider mix for obstetrics was developed specifically for obstetrical clinical services and is not generalizable to other inpatient clinical services.

D. DATA COLLECTION AND DATA ANALYSIS

1. Validity Determination.

Validity studies were conducted to determine if the Obstetric Patient Classification Subsystem demonstrated content-related and criterion-related validity. Professional nursing judgment was involved in the original design of the obstetric patient classification instrument and was again required for validation of the content of the instrument. It is of importance to note that during all data collection efforts, the participants had the option of and were encouraged to indicate inadequacies in the Obstetric Patient Classification Subsystem and suggest modifications.

Correlation coefficients were computed for the documented direct nursing care requirements with the obstetric patient classification instrument mathematical model for two independent testings and these correlation coefficients are displayed in Table 3.

Table 3
Validity: Correlation Coefficients for Documented Direct
Nursing Care Requirements with the Obstetric Patient
Classification Instrument Mathematical Model

Obstetric	Correlation Coefficients	
	Test 1	Test 2
Direct Nursing Care Requirements		
Mathematical Model	.98	.99

Observational studies were conducted to determine the relationship of the obstetric patient classification instrument to the actual observed and timed measurements of direct nursing care activities. The criterion-related validity coefficients for obstetrics are displayed in Table 4.

Timed measurements refer to the actual measurements by stopwatch; observed frequencies refer to actual observed frequency rates for each direct nursing care activity; and hours of care were established utilizing the appropriate minimal essential mean tasking time. Assessed requirements refer to the total hours of care established through consensus nursing judgment. As shown in Table 4 the criterion-related validity coefficients for obstetrics were $r = .99$.

Table 4

Criterion-Related Validity Coefficients for Timed Measurements,
Observed Frequencies and Assessed Requirements

Hours of Direct Nursing Care	24-Hour Study Period			
	Mean	SD	95% CI	Pearson's r
Timed Measurements	1.62	2.31	.81-4.04	.99
Observed Frequencies	1.71	2.69	1.11-4.53	
Timed Measurements	1.62	2.31	.81-4.04	.99
Assessed Requirements	1.81	2.91	1.25-4.86	
Observed Frequencies	1.71	2.69	1.11-4.53	.99
Assessed Requirements	1.81	2.91	1.25-4.86	

2. Reliability Determination.

Reliability studies were conducted to determine: (a) if the obstetric patient classification instrument demonstrated statistically significant interrater reliability for inpatient classification; and (b) if the individual patient care indicators displayed internal consistency.

Prior to initiation of the interrater reliability studies, the professional nurse raters received an orientation to and standardized instructions about the instruments used in the study. A two-hour orientation period was held for group presentation, followed by individual orientation by the project officer. The raters were given a minimum of ten days in which to practice rating patients using the Obstetric Patient Classification Subsystem.

A schedule of data collection for the obstetrical clinical units was devised to allow for rating of patients on two preselected days per week. The study was conducted over an eight-week period with sixteen data collection days. The time-span schedule, commencing in September 1980 and ending in January 1981, required four months to complete. The data collection periods were staggered to allow for the project officer to initiate the study within four medical treatment facilities as follows: William Beaumont Army Medical Center; Eisenhower Army Medical Center; Darnall US Army Community Hospital, Fort Hood; and Womack US Army Community Hospital, Fort Bragg.

Sixteen data collection periods were conducted within the four medical treatment facilities. Ratings were completed on the entire inpatient population of all obstetrical clinical units. Each of the 1128 inpatients were rated by independent, trained pairs of professional nurse raters. In order to establish a level of quality control for the data collection efforts at the unit level, the forms were collected by a facility project officer. The facility project officer was responsible for checking the instruments for completeness, legibility, reconstruction of any missing data and pairing the match pairs of data from the two professional nurse raters. At the end of each week, the facility project officer mailed the completed instruments to HCSD using the preaddressed envelopes provided by HCSD. The HCSD staff edited each instrument and recomputed all scores to assure accuracy prior to coding of data for keypunching.

The population consisted of 1128 inpatients with a mean age of 24 years. The description of the patient population is presented in order to provide a framework for the analysis of the study results. The category of care by age group for rater one vs rater two is shown in Table 5.

Table 5

Category of Care by Age Group for Rater One vs Rater Two
N = 1128

		Age Groups			
		4	5	6	
Category of Care	1	Rater One Rater Two	1 2	283 265	143 142
	2	Rater One Rater Two	2 1	275 304	131 135
	3	Rater One Rater Two	0 0	173 162	59 56
	4	Rater One Rater Two	0 0	45 42	7 7
	5	Rater One Rater Two	1 1	3 6	2 2

Age Groups: 4 = 12 thru 15 years
5 = 16 thru 25 years
6 = 26 thru 55 years

The descriptive data of the patient care indicator scores for rater one vs rater two for the total population are shown in Table 6.

Table 6
Descriptive Data of Patient Care Indicator Scores
for Rater One vs Rater Two

	Mean	SD	N
Rater One	63.45	47.22	1128
Rater Two	63.10	47.09	1128

Category of care distribution by days of the week for rater one vs rater two are shown in Table 7.

Table 7
Category of Care by Days of the Week for Rater One vs Rater Two
N = 1128

		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Category of Care	1	Rater One 69	97	63	78	50	39	34
		Rater Two 63	86	73	76	47	35	32
	2	Rater One 73	92	66	53	41	29	54
		Rater Two 82	104	58	56	46	34	60
	3	Rater One 39	27	27	42	35	34	28
		Rater Two 35	29	25	37	34	33	25
	4	Rater One 6	10	6	9	14	4	3
		Rater Two 7	8	6	13	9	4	2
	5	Rater One 1	1	2	0	2	0	0
		Rater Two 1	0	2	0	6	0	0

In the determination of interrater reliability two sets of ratings, one for total score and one for category of care, were obtained from the assessment of each of the 1128 inpatients by two independently trained raters representing four medical treatment facilities. These data were analyzed using the Pearson's correlation coefficient with a resultant reliability coefficient for total score and category of care. Table 8 displays the obstetric patient classification instrument frequency distribution: rater one vs rater two for category of care. Pearson's correlation coefficient for category of care rater one vs rater two, $r = .88$.

Table 8

Obstetric Patient Classification Instrument
Frequency Distribution: Rater One vs Rater Two for Category of Care

N = 1128

		Category of Care for Rater Two				
		1	2	3	4	5
Category of Care Rater One	1	352	73	2	0	0
	2	54	343	13	0	0
	3	3	26	193	10	1
	4	0	0	11	38	3
	5	0	0	0	1	5

Pearson's r for category of care rater one vs rater two, $r = .88$.

Concurrently, Table 9 displays the correlation coefficient for total patient care indicator score (PCIS) by category of care Pearson's correlation coefficient for total PCIS rater one vs rater two across categories, $r = .95$. In addition, all coefficients for total score and category of care were significant ($p < .001$).

Table 9

Obstetric Patient Classification Instrument
Total Patient Care Indicator Score (PCIS) by Category of Care

Category of Care	PCIS		Mean	SD	95% CI	N
	Rater One	Rater Two				
1	Rater One	1-39	25.33	8.54	24.52-26.14	427
	Rater Two		25.31	8.57	24.48-26.14	409
2	Rater One	40-79	55.72	11.22	54.63-56.81	410
	Rater Two		55.31	11.68	54.22-56.41	440
3	Rater One	80-159	114.81	22.54	111.90-117.72	233
	Rater Two		114.91	22.94	111.85-117.96	218
4	Rater One	160-239	185.28	23.27	173.80-191.76	52
	Rater Two		181.74	23.98	174.86-188.63	49
5	Rater One	240-499	268.17	17.13	250.19-286.14	6
	Rater Two		263.44	45.92	228.15-298.74	9

Pearson's r for total PCIS rater one vs rater two across categories, $r = .95$.

To establish internal consistency of the obstetric patient classification instrument, two independent raters' patient care indicator scores were analyzed to determine if the individual responses to the various patient care indicators were consistent. Correlation coefficients were used to indicate the degree to which variation in the patient care indicator scores for rater one was related to variation in the patient care indicator scores for rater two. Hence, the correlation coefficient summarizes the strength of the association, or agreement in this case, between the scores for rater one and the scores for rater two. Pearson's product-moment correlations for pairs of variables are presented in Table 10. Significance tests are reported for each coefficient and are derived from the student's t with $N-2$ degrees of freedom. Strong coefficients were found for rater one vs rater two scores in categories one through four. Since the number of cases in category five was less than three, coefficients and significance tests were not computed.

Table 10

OBSTETRIC PATIENT CLASSIFICATION INSTRUMENT
INTERCORRELATIONS OF PATIENT CARE INDICATOR SCORES

	Hygiene	Nutrition/ Elimination	Mobility/ Exercise/ Safety	Psycholog- ical/ Patient Teaching	Vital Signs /Assess- ment/Diag- nostic Tests	Gastroin- testinal	Respira- tory	Cardio- vascular	Skin	Skeletal/ Urological/ Gynecolo- gical	Obstet- rical	Other Therapeu- tic Acti- vities/ Modalities
Category 1 (<1-1 hour) (df = 192)	r = .851 p < .001	r = .717 p < .001	r = .711 p < .001	r = .459 p < .001	r = .572 p < .001	r = .630 p < .001	r = .349 p < .001	r = .888 p < .001	r = .627 p < .001	r = .480 p < .001	r = .898 p < .001	r = .941 p < .001
Category 2 (2-3 hours) (df = 162)	r = .855 p < .001	r = .802 p < .001	r = .708 p < .001	r = .761 p < .001	r = .812 p < .001	r = .660 p < .001	r = .819 p < .001	r = .839 p < .001	r = .667 p < .001	r = .679 p < .001	r = .949 p < .001	No Entries
Category 3 (4-7 hours) (df = 100)	r = .735 p < .001	r = .758 p < .001	r = .829 p < .001	r = .919 p < .001	r = .726 p < .001	r = .905 p < .001	r = .703 p < .001	r = .675 p < .001	r = .500 p < .001	r = .627 p < .001	r = .981 p < .001	No Entries
Category 4 (8-11 hours) (df = 15)	r = .972 p < .001	r = .768 p < .001	r = .930 p < .001	r = .947 p < .001	r = .911 p < .001	r = .937 p < .001	r = .859 p < .001	r = .948 p < .001	r = .716 p < .001	r = .943 p < .001	r = .941 p < .001	No Entries
Category 5 (12-24 hours)	*	*	*	*	*	*	*	*	*	*	*	No Entries

* Count less than 3

E. CONCLUSIONS

The Obstetric Patient Classification Subsystem has been developed and tested through four years of rigorous field research. This quantitative subsystem measures direct nursing care activities and determines the best mix by skill level of care providers for obstetrical inpatients. The Obstetric Patient Classification Subsystem utilizes the factor-evaluation design, is multidimensional, and is designed for automated or manual implementation. Extensive validity and reliability studies demonstrate that the Obstetric Patient Classification Subsystem is valid and reliable.

APPENDIX A

Obstetric Patient Classification Instrument Mathematical Model

OBSTETRIC PATIENT CLASSIFICATION INSTRUMENT

MATHEMATICAL MODEL

ACTIVITY
(MEAN)
(FREQUENCY)
TOTAL SCORE
WEIGHTED SCORE

HYGIENE:

Bathing, Complete
(20.1646)
(1)
20.1646
7

Bathing, Assist with
Back and Legs
(12.1010)
(1)
12.1010
4

Bathing, Utensils
Provided
(2.5201)
(1)
2.5201
1

Sitting Shower/Shower
with Assistance
(16.7945)
(1)
16.7945
6

AM Care
(6.9666)
(1)
6.9666
2

AM Care, Partial/
Utensils Provided
(3.3273)
(1)
3.3273
1

Oral Hygiene (3.2428)	(1) 3.2428 1	(2) 6.4856 2	(3) 9.7284 3	(6) 19.4568 6	(9) 29.1852 10	(12) 38.9136 13
--------------------------	--------------------	--------------------	--------------------	---------------------	----------------------	-----------------------

Skin Care/Back Rub (3.3118)	(1) 3.3118 1	(2) 6.6236 2	(3) 9.9354 3	(6) 19.8708 7	(9) 29.8062 10	(12) 39.7416 13
--------------------------------	--------------------	--------------------	--------------------	---------------------	----------------------	-----------------------

PM Care
(10.6934)
(1)
10.6934
4

Unoccupied Bed (6.0472)	(1) 6.0472 2	(2) 12.0944 4	(3) 18.1416 6	(4) 24.1888 8	(5) 30.2360 10	(6) 36.2832 12
----------------------------	--------------------	---------------------	---------------------	---------------------	----------------------	----------------------

Occupied Bed (9.6977)	(1) 9.6977 3	(2) 19.3954 6	(3) 29.0931 10
--------------------------	--------------------	---------------------	----------------------

Changing Bed Linen Protector/Chux (1.0063)	(3) 3.0189 1	(6) 6.0378 2	(12) 12.0756 4	(18) 18.1134 6	(24) 24.1512 8	(30) 30.1890 10
--	--------------------	--------------------	----------------------	----------------------	----------------------	-----------------------

ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE
--------------------	--

NUTRITION/ELIMINATION:

Feeding (16.1591)	(1) 16.1591 5	(2) 32.3182 11	(3) 48.4773 16			
Fluid (.9525)	(1) .9525 .5	(2) 1.9050 .5	(3) 2.8575 1	(6) 5.7150 2	(9) 8.5725 3	(12) 11.4300 4
Snack (.8472)	(1) .8472 .5	(2) 1.6944 .5	(3) 2.5416 1			
Serving Meal Tray, Preparation Required (2.6073)	(1) 2.6073 1	(2) 5.2146 2	(3) 7.8219 3			
Serving Meal Tray, No Preparation Required (.3881)	(1) .3881 .5	(2) .7762 .5	(3) 1.1643 .5			
Measuring and Recording Intake (.8583)	(3) 2.5749 1	(6) 5.1498 2	(9) 7.7247 3	(12) 10.2996 3	(18) 15.4494 5	(24) 20.5992 7
Measuring and Recording Output - Urine/Vomitus/ Drainage Bottles, All Types (1.2098)	(3) 3.6294 1	(6) 7.2588 2	(9) 10.8882 4	(12) 14.5176 5	(18) 21.7764 7	(24) 29.0352 10
Giving a Bedpan (2.5998)	(1) 2.5998 1	(2) 5.1996 2	(3) 7.7994 3	(6) 15.5988 5	(9) 23.3982 8	(12) 31.1976 10

MOBILITY/EXERCISE/SAFETY:

Changing Patient's Position in Bed (2.1266)	(1) 2.1266 1	(2) 4.2532 1	(3) 6.3798 2	(6) 12.7596 4	(9) 19.1394 6	(12) 25.5192 9
Adjusting Position of Bed (.4927)	(1) .4927 .5	(2) .9854 .5	(3) 1.4781 .5	(6) 2.9562 1	(9) 4.4343 1	(12) 5.9124 2
Mobility - Ambulating First Time/Assistance While Walking (4.6640)	(1) 4.6640 2	(2) 9.3280 3	(3) 13.9920 5	(6) 27.9840 9	(9) 41.9760 14	(12) 55.9680 19
Mobility - Bed to Chair (4.9488)	(1) 4.9488 2	(2) 9.8976 3	(3) 14.8464 5	(6) 29.6928 10	(9) 44.5392 15	(12) 59.3856 20

ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE					
Mobility - Bed to Stretcher (4.9424)	(1) 4.9424 2	(2) 9.8848 3	(3) 14.8272 5	(6) 29.6544 9		
Mobility - Bed to Floor/Sitting on Side of Bed (1.7997)	(1) 1.7997 .5	(2) 3.5994 1	(3) 5.3991 2			
Exercise - Active (7.0733)	(1) 7.0733 2	(2) 14.1466 5	(3) 21.2199 7	(6) 42.4398 14	(9) 63.6597 21	(12) 84.8796 28
Adjusting Siderail (.3696)	(8) 2.9568 1	(12) 4.4352 1	(24) 8.8704 3	(36) 13.3056 4	(48) 17.7408 6	(96) 35.4816 12

PSYCHOLOGICAL/PATIENT TEACHING:

Orientation to Clinical Unit (4.7997)	(1) 4.7997 2	(2) 9.5994 3	(3) 14.3991 5			
Explanation of Procedures and Tests (1.7433)	(1) 1.7433 .5	(2) 3.4866 1	(4) 6.9732 2	(6) 10.4598 3	(12) 20.9196 7	(60) 104.5980 35
Answering Patient's Question (1.0121)	(6) 6.0726 2	(12) 12.1452 4	(18) 18.2178 6	(24) 24.2904 8	(36) 36.4356 12	(48) 48.5808 16
Visting with Patient/ Purposeful Interaction (2.1036)	(6) 12.6216 4	(12) 25.2432 8	(24) 50.4864 17	(36) 75.7296 25	(48) 100.9728 34	(96) 201.9456 67
Teaching - Medication Administration (19.5881)	(1) 19.5881 7					
Teaching - Urine Testing (1.2580)	(1) 1.2580 .5					
Teaching - Disease/ Condition Related (6.1507)	(1) 6.1507 2	(2) 12.3014 4	(3) 18.4521 6	(6) 36.9042 12	(9) 55.3563 18	(12) 73.8084 25
Teaching - Blow Bottles/ Incentive Spirometer (3.5971)	(1) 3.5971 1	(2) 7.1942 2	(3) 10.7913 4			
Teaching - Dietary Explanation (2.8633)	(1) 2.8633 1	(2) 5.7266 2	(3) 8.5899 3			

ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE					
Teaching - Preoperative (10.2056)	(1) 10.2056 3	(2) 20.4112 7				
Teaching - Diagnostic Test (1.0804)	(1) 1.0804 .5	(2) 2.1608 1				
Teaching - Perineal Suture Care (2.4383)	(1) 2.4383 1	(2) 4.8766 2				
Teaching - Breast Feeding (12.6888)	(1) 12.6888 4	(2) 25.3776 8	(3) 38.0664 13	(4) 50.7552 17	(6) 76.1328 25	(8) 101.5104 34
Teaching - Bottle Feeding (8.5260)	(1) 8.5260 3	(2) 17.0520 6	(3) 25.5780 9	(6) 51.1560 17		
Teaching - Breast Care (2.8025)	(1) 2.8025 1	(2) 5.6050 2	(3) 8.4075 3	(4) 11.2100 4	(5) 14.0125 5	(6) 16.8150 6

VITAL SIGNS/ASSESSMENT/DIAGNOSTIC TESTS:

Blood Pressure, Manual (1.0388)	(2) 2.0776 1	(6) 6.2328 2	(12) 12.4656 4	(24) 24.9312 8	(48) 49.8624 17	(96) 99.7248 33
Oral Temperature, Pulse and Respirations (1.2903)	(1) 1.2903 .5	(3) 3.8709 1	(6) 7.7418 3	(12) 15.4836 5	(18) 23.2254 8	(24) 30.9672 10
Pulse - Apical (1.3296)	(1) 1.3296 .5	(2) 2.6592 1	(3) 3.9888 1	(6) 7.9776 3	(12) 15.9552 5	(24) 31.9104 11
Pulse - Radial/ Brachial (.6727)	(1) .6727 .5	(2) 1.3454 .5	(3) 2.0181 1	(6) 4.0362 1	(12) 8.0724 3	(24) 16.1448 5
Temperature - Oral/ Rectal/Axillary (1.2370)	(1) 1.2903 .5	(2) 2.4740 1	(3) 3.7110 1	(6) 7.4220 2	(12) 14.8440 5	(24) 29.6880 10
Respirations (.6605)	(1) .6605 .5	(2) 1.3210 .5	(3) 1.9815 .5	(6) 3.9630 1	(12) 7.9260 3	(24) 15.8520 5
Pulmonary Assessment (1.6746)	(1) 1.6746 .5	(2) 3.3492 1	(3) 5.0238 2	(4) 6.6984 2	(6) 10.0476 3	(12) 20.0952 7

ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE					
Bowel Sound Assessment (1.5112)	(1) 1.5112 .5	(2) 3.0224 1	(3) 4.5336 1	(4) 6.0448 2	(5) 7.5560 3	(6) 9.0672 3
Ambulatory Weight (1.2309)	(1) 1.2309 .5	(2) 2.4618 1				
Orientation (.9941)	(1) .9941 .5	(3) 2.9823 1	(6) 5.9646 2	(12) 11.9292 4	(24) 23.8584 8	(48) 47.7168 16
Mental Alertness (.9056)	(1) .9056 .5	(3) 2.7168 1	(6) 5.4336 2	(12) 10.8672 4	(24) 21.7344 7	(48) 43.4688 14
Motor/Sensory Testing (1.1761)	(1) 1.1761 .5	(3) 3.5283 1	(6) 7.0566 2	(12) 14.1132 5	(24) 28.2264 9	(48) 56.4528 19
Pupil Reflexes (.6611)	(1) .6611 .5	(3) 1.9833 .5	(6) 3.9666 1	(12) 7.9332 3	(24) 15.8664 5	
Urine Testing - Protein/ Specific Gravity/Sugar and Acetone (1.0835)	(1) 1.0835 .5	(2) 2.1670 1	(3) 3.2505 1	(6) 6.5010 2	(12) 13.0020 4	(24) 26.0040 9
Situational Observation (28.2554)	(1) 28.2554 9	(2) 56.5108 19	(3) 84.7662 28			

MEDICATION:

Oral (.8085)	(1) .8085 .5	(2) 1.6170 .5	(3) 2.4255 1	(4) 3.2340 1	(6) 4.8510 2	(9) 7.2765 2
Intramuscular (1.2259)	(1) 1.2259 .5	(2) 2.4518 1	(3) 3.6777 1	(4) 4.9036 2	(6) 7.3554 2	(9) 11.0331 4
Subcutaneous (.9010)	(1) .9010 .5	(2) 1.8020 .5	(3) 2.7030 1	(4) 3.6040 1	(6) 5.4060 2	(9) 8.1090 3
Topical (1.2234)	(1) 1.2234 .5	(2) 2.4468 1	(3) 3.6702 1	(4) 4.8936 2	(6) 7.3404 2	(9) 11.0106 4
Suppository, Rectal/Vaginal (1.4799)	(1) 1.4799 .5	(2) 2.9598 1	(3) 4.4397 1			

ACTIVITY
(MEAN)

(FREQUENCY)
TOTAL SCORE
WEIGHTED SCORE

GASTROINTESTINAL:

Nasogastric Tube - Insertion (8.0006)	(1) 8.0006 3					
Nasogastric Tube - Removal (1.4648)	(1) 1.4648 .5					
Nasogastric Tube - Irrigation/Instillation (2.0037)	(1) 2.0037 1	(2) 4.0074 1	(3) 5.0111 2	(4) 8.0148 3	(5) 10.0185 3	(6) 12.0222 4
Enema - Cleansing (4.7160)	(1) 4.7160 2	(2) 9.4320 3	(3) 14.1480 5			
Enema - Retention (1.8452)	(1) 1.8452 .5	(2) 3.6904 1	(3) 5.5356 2			

RESPIRATORY:

Oxygen Administration (.8998)	(4) 3.5992 1	(8) 7.1984 2	(12) 10.7976 4	(16) 14.3968 5	(24) 21.5952 7	(32) 28.7936 10
Cough and Deep Breathe (2.2805)	(2) 4.5610 2	(4) 9.1220 3	(6) 13.6830 5	(8) 18.2440 6	(10) 22.8050 8	(12) 27.3660 9
Blow Bottles/ Incentive Spirometer (3.2065)	(2) 6.4130 2	(4) 12.8260 4	(6) 19.2390 6			

CARDIOVASCULAR:

Venipuncture - Blood Sample/Culture (4.2459)	(1) 4.2459 1	(2) 8.4918 3	(3) 12.7377 4	(4) 16.9836 6	(6) 25.4754 8	(8) 33.9672 11
Intravenous Infusion - Initiating (9.2432)	(1) 9.2432 3	(2) 18.4864 6	(3) 27.7296 9			
Intravenous Infusion - Flow Rate (.7528)	(3) 2.2584 1	(6) 4.5168 2	(12) 9.0336 3	(24) 18.0672 6	(48) 36.1344 12	(96) 72.2688 24
Intravenous Infusion - Changing IV Bottle (1.6528)	(1) 1.6528 .5	(2) 3.3056 1	(3) 4.9584 2	(4) 6.6112 2	(6) 9.9168 3	(10) 16.5280 5

ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE					
Intravenous Infusion - IV Push Medication/ Piggyback Medication (1.8793)	(1) 1.8793 .5	(2) 3.7586 1	(3) 5.6379 2	(4) 7.5172 3	(8) 15.0344 5	(12) 22.5516 8
Intravenous Infusion - IV Catheter Care (9.7106)	(1) 9.7106 3	(2) 19.4212 5				
Intravenous Infusion - Infusion Pump Setup (3.6533)	(1) 3.6533 1	(2) 7.3066 2	(5) 10.9599 4	(4) 14.6132 5	(5) 18.2665 6	(6) 21.9198 7
Intravenous Infusion - Platelets/Plasma/Blood (3.6441)	(1) 3.6441 1	(2) 7.2882 2	(3) 10.9323 4	(4) 14.5764 5	(5) 18.2205 6	(6) 21.8646 7
Intravenous Infusion/ Arterial Line - Termination (3.2334)	(1) 3.2334 1	(2) 6.4668 2				
Elastic Stockings (3.4109)	(1) 3.4109 1	(2) 6.8218 2				
<u>SKIN:</u>						
Surgical Prep, Local (10.9932)	(1) 10.9932 4					
Surgical Prep, 3-Way (16.6240)	(1) 16.6240 6					
Suture/Skin Clip Removal, \geq 15 (14.4313)	(1) 14.4313 5					
Suture/Skin Clip Removal, < 15 (6.2072)	(1) 6.2072 2					
Small Dressing Change, < 4" x 8" (6.1654)	(1) 6.1654 2	(2) 12.3308 4	(3) 18.4962 6			
Wound Culture (2.3122)	(1) 2.3122 1	(2) 4.6244 1				
Sitz Bath (10.6256)	(1) 10.6256 4	(2) 21.2512 7	(3) 31.8768 11	(4) 42.5024 14		

ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE					
K-Pad Application (1.4550)	(1) 1.4550 .5	(2) 2.9100 1	(3) 4.3650 1	(6) 8.7300 3	(9) 13.0950 4	(12) 17.4600 6
Heat Lamp Application (1.6084)	(1) 1.6084 .5	(2) 3.2168 1	(3) 4.8252 2	(4) 6.4336 2	(5) 8.0420 3	(6) 9.6504 3

SKELETAL/UROLOGICAL/GYNECOLOGICAL:

Ice Pack (.8001)	(1) .8001 .5	(2) 1.6002 .5	(3) 2.4003 1	(4) 3.2004 1	(5) 4.0005 1	(6) 4.8006 2
Extremity Elevation (.9140)	(1) .9140 .5	(2) 1.8280 .5	(3) 2.7420 1	(4) 3.6560 1	(5) 4.5700 2	(6) 5.4840 2
Catheterization - Foley/Straight (7.2299)	(1) 7.2299 2					
Foley Catheter Care/ Foley Catheter Removal (3.8739)	(1) 3.8739 1	(2) 7.7478 3	(3) 11.6217 4			
Urine Specimen - Routine/Clean Catch/ Foley (1.9167)	(1) 1.9167 .5	(2) 3.8334 1	(3) 5.7501 2			
Perineal Care (2.3750)	(1) 2.3750 1	(2) 4.7500 2	(3) 7.1250 2	(4) 9.5000 3	(5) 11.8750 4	(6) 14.2500 5
Vaginal/Pelvic Examination (5.6741)	(1) 5.6741 2	(2) 11.3482 4	(3) 17.0223 6			

OBSTETRICAL:

Labor Room Examination and Preparation, Routine (26.0294)	(1) 26.0294 9					
Fetal Heart Tones, Manual/Doppler (1.8021)	(1) 1.8021 .5	(2) 3.6042 1	(3) 5.4063 2	(4) 7.2084 2	(6) 10.8126 4	(9) 16.2189 5
Dilatation and Effacement Assessment (1.7765)	(1) 1.7765 .5	(2) 3.5530 1	(3) 5.3295 2	(6) 10.6590 4	(9) 15.9885 5	(12) 21.3180 7
Support During Contraction (2.1680)	(12) 26.0160 9	(18) 39.0240 13	(24) 52.0320 17	(48) 104.0640 35	(72) 156.0960 52	(96) 208.1280 69

ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE					
Manual Contraction Assessment (1.8905)	(1) 1.8905 .5	(3) 5.6715 2	(6) 11.3430 4	(9) 17.0145 6	(16) 30.2480 10	(32) 60.4960 20
Ultrasonic Transducer - Application (2.1920)	(1) 2.1920 1					
Tocotransducer - Application (2.1377)	(1) 2.1377 1					
Adjust Ultrasonic Transducer/ Tocotransducer (2.9279)	(1) 2.9279 1	(3) 8.7837 3	(6) 17.5674 6	(9) 26.3511 9	(18) 52.7022 18	(36) 105.4044 35
Amniotomy (3.4025)	(1) 3.4025 1					
Fetal Electrode Insertion (3.5817)	(1) 3.5817 1					
Intrauterine Catheter Insertion (9.2133)	(1) 9.2133 3	(2) 18.4266 6				
Internal or External Monitoring - Uterine Contraction/Fetal Heart Tones (1.0861)	(12) 13.0332 4	(24) 26.0664 9	(48) 52.1328 17	(72) 78.1992 26	(96) 104.2656 35	
Observation and Assessment, Second Stage Labor (52.4420)	(1) 52.4420 17					
Routine Delivery Room Functions (56.7940)	(1) 56.7940 19					
Fundus Massage (.9519)	(1) .9519 .5	(3) 2.8557 1	(4) 3.8076 1	(6) 5.7114 2	(9) 8.5671 3	(12) 11.4228 4
Changing Perineal Pad (.7891)	(1) .7891 .5	(3) 2.3673 1	(6) 4.7346 2	(9) 7.1019 2	(12) 9.4692 3	(16) 12.6256 4
Perineal Suture Care (2.8530)	(2) 5.7060 2	(3) 8.5590 3	(4) 11.4120 4	(6) 17.1180 6	(8) 22.8240 8	(10) 28.5300 10

ACTIVITY (MEAN)	(FREQUENCY) TOTAL SCORE WEIGHTED SCORE		
Postpartum Assessment (2.0210)	(1) 2.0210 1	(2) 4.0420 1	(3) 6.0630 2
Pitocin Induction (6.5417)	(1) 6.5417 2		
Amniocentesis (29.1840)	(1) 29.1840 10		
Non-Stress Test (24.3193)	(1) 24.3193 8		
Oxytocin Challenge Test (61.4033)	(1) 61.4033 20		

APPENDIX B
Obstetric Patient Classification Instrument

CR

October 15

Received of Mr. J. H. Smith

the sum of \$100.00

for rent of land

a. Patient's Hospital Card

OBSTETRICAL PATIENT CLASSIFICATION
INSTRUMENT

TOTAL PCIS Points	WEIGHTED SCORE (Points)	CATEGORY (Circle One)
	1 - 39	1
	40 - 79	2
	80 - 159	3
	160 - 239	4
	240 - 499	5

b. DATE: _____

c. RATER'S NAME: _____

HYGIENE

Bathing, Complete FREQUENCY SCORE
Bathing, Assist with Back and Legs
Bathing, Utensils Provided
Sitting Shower/Shower with Assistance
AM Care.
AM Care, Partial/Utensils Provided

1
7
4
1
6
2
1

Oral Hygiene
Skin Care /Back Rub.
PM Care.

1	2	3	6	9	12
1	2	3	6	10	13
1	2	3	7	10	13
4					

Unoccupied Bed
Occupied Bed

1	2	3	4	5	6
2	4	6	8	10	12
3	6	10			

Changing Bed Linen Protector/Chux

3	6	12	18	24	30
1	2	4	6	8	10

PCIS .
13-15 16

NUTRITION/ELIMINATION

Feeding FREQUENCY SCORE
Fluid
Snack
Serving Meal Tray, Preparation Required
Serving Meal Tray, No Preparation Required

1	2	3
5	11	16

1	2	3	6	9	12
.5	.5	1	2	3	4
.5	.5	1			
1	2	3			
.5	.5	.5			

Measuring and Recording Intake
Measuring and Recording Output - Urine/
Vomitus/Drainage Bottles, All Types

3	6	9	12	18	24
1	2	3	3	5	7
1	2	4	5	7	10

Giving a Bedpan.

1	2	3	6	9	12
1	2	3	5	8	10

PCIS .
17-19 20

MOBILITY/EXERCISE/SAFETY

	FREQUENCY					
	1	2	3	6	9	12
Changing Patient's Position in Bed..... SCORE	1	1	2	4	6	9
Adjusting Position of Bed . . . . .	.5	.5	.5	1	1	2
Mobility - Ambulating First Time/ Assistance While Walking.	2	3	5	9	14	19
Mobility - Bed to Chair	2	3	5	10	15	20
Mobility - Bed to Stretcher	2	3	5	9		
Mobility - Bed to Floor/Sitting on Side of Bed	.5	1	2			
Exercise - Active	2	5	7	14	21	28
Adjusting Siderail.'	8	12	24	36	48	96
	1	1	3	4	6	12

PCIS .
21-23 24

PSYCHOLOGICAL/PATIENT TEACHING

	FREQUENCY		
	1	2	3
Orientation to Clinical Unit SCORE	2	3	5
Explanation of Procedures and Tests. . . . .	.5	1	2
	6	12	18
Answering Patient's Question	2	4	6
	8	12	16
Visiting with Patient/Purposeful Interaction	6	12	24
	4	8	17
Teaching - Medication Administration	1		
Teaching - Urine Testing . . . . .	.5		
Teaching - Disease/Condition Related	1	2	3
Teaching - Blow Bottles/Incentive Spirometer	2	4	6
Teaching - Dietary Explanations.	1	2	4
Teaching - Preoperative.	1	2	3
Teaching - Diagnostic Test	3	7	
Teaching - Perineal Suture Care. . . . .	.5	1	
	1	2	
Teaching - Breast Feeding.	1	2	3
	4	8	13
Teaching - Bottle Feeding.	1	2	3
	3	6	9
Teaching - Breast Care	1	2	3
	1	2	3

PCIS .
25-27 28

VITAL SIGNS/ASSESSMENT/DIAGNOSTIC TESTS

	FREQUENCY	2	6	12	24	48	96
Blood Pressure, Manual.	SCORE	1	2	4	8	17	33
Oral Temperature, Pulse, and Respirations . .		1	3	6	12	18	24
		.5	1	3	5	8	10
Pulse - Apical.		1	2	3	6	12	24
Pulse - Radial/Brachial . . . . .		.5	1	1	3	5	11
Temperature - Oral/Rectal/Axillary. . . . .		.5	.5	1	1	3	5
Respirations. . . . .		.5	1	1	2	5	10
		.5	.5	.5	1	3	5
Pulmonary Assessment.		1	2	3	4	6	12
		.5	1	2	2	3	7
Bowel Sound Assessment.		1	2	3	4	5	6
Ambulatory Weight . . . . .		.5	1	1	2	3	3
		.5	1				
Orientation		1	3	6	12	24	48
Mental Alertness. . . . .		.5	1	2	4	8	16
Motor/Sensory Testing . . . . .		.5	1	2	4	7	14
Pupil Reflexes. . . . .		.5	1	2	5	9	19
		.5	.5	1	3	5	
Urine Testing - Protein/Specific Gravity/ Sugar and Acetone		1	2	3	6	12	24
Situational Observation . . . . .		.5	1	1	2	4	9
		9	19	28			

PCIS .
29-31 32

MEDICATION

	FREQUENCY	1	2	3	4	6	9
Oral	SCORE	.5	.5	1	1	2	2
Intramuscular . . . . .		.5	1	1	2	2	4
Subcutaneous . . . . .		.5	.5	1	1	2	3
Topical . . . . .		.5	1	1	2	2	4
Suppository, Rectal/Vaginal. . . . .		.5	1	1			

PCIS .
33-35 36

GASTROINTESTINAL

	FREQUENCY	1					
Nasogastric Tube - Insertion	SCORE	3					
Nasogastric Tube - Removal . . . . .		.5					
Nasogastric Tube - Irrigation/Instillation .		1	2	3	4	5	6
Enema - Cleansing		1	1	2	3	3	4
Enema - Retention		2	3	5			
		.5	1	2			

PCIS .
37-39 40

RESPIRATORY

	FREQUENCY	4	8	12	16	24	32
Oxygen Administration.	SCORE	1	2	4	5	7	10
Cough and Deep Breathe		2	4	6	8	10	12
Blow Bottles/Incentive Spirometer.		2	3	5	6	8	9
		2	4	6			

PCIS .
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CARDIOVASCULAR

	FREQUENCY					
	1	2	3	4	6	8
Venipuncture - Blood Sample/Culture . . . SCORE	1	3	4	6	8	11
IV Infusion - Initiating	3	6	9			
IV Infusion - Flow Rate	3	6	12	24	48	96
	1	2	3	6	12	24
IV Infusion - Changing IV Bottle	1	2	3	4	6	10
	.5	1	2	2	3	5
IV Infusion - IV Push Medication/Piggyback Medication	1	2	3	4	8	12
	.5	1	2	3	5	8
IV Infusion - IV Catheter Care	3	6				
IV Infusion - Infusion Pump Setup	1	2	3	4	5	6
	1	2	4	5	6	7
IV Infusion - Platelets/Plasma/Blood	1	2	4	5	6	7
	1	2				
IV Infusion/Arterial Line - Termination	1	2				
Elastic Stockings	1	2				

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SKIN

	FREQUENCY					
	1	2	3	4	6	8
Surgical Prep, Local SCORE	4					
Surgical Prep, 3-Way	6					
Suture/Skin Clip Removal, \geq 15	5					
Suture/Skin Clip Removal, $<$ 15	2					
Small Dressing Change, $<$ 4" x 8"	1	2	3			
	2	4	6			
Wound Culture	1	1				
Site Bath	1	2	3	4		
	4	7	11	14		
K-Pad Application	1	2	3	6	9	12
	.5	1	1	3	4	6
Heat Lamp Application	1	2	3	4	5	6
	.5	1	2	2	3	3

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SKELETAL/UROLOGICAL/GYNECOLOGICAL

	FREQUENCY					
	1	2	3	4	5	6
Ice Pack SCORE	.5	.5	1	1	1	2
Extremity Elevation . . . . .	.5	.5	1	1	2	2
Catheterization - Foley /Straight	2					
Foley Catheter Care/Foley Catheter Removal	1	2	3			
	1	3	4			
Urine Specimen - Routine/Clean Catch/Foley5	1	2			
Perineal Care	1	2	3	4	5	6
	1	2	2	3	4	5
Vaginal/Pelvic Examination	1	2	3			
	2	4	6			

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OBSTETRICAL

	FREQUENCY SCORE					
Labor Room Examination and Preparation, Routine.	1	2	3	4	5	6
	9					
Fetal Heart Tones, Manual/Doppler	1	2	3	4	5	6
	.5	1	2	2	4	5
Dilatation and Effacement Assessment.	1	2	3	4	5	6
	.5	1	2	4	5	7
Support During Contraction.	12	18	24	48	72	96
	9	13	17	35	52	69
Manual Contraction Assessment	1	3	6	9	16	32
Ultrasonic Transducer - Application . . . . .	.5	2	4	6	10	20
Tocotransducer - Application.	1					
	1					
Adjust Ultrasonic Transducer/Tocotransducer	1	3	6	9	18	36
Amniotomy	1	3	6	9	18	35
Fetal Electrode Insertion	1					
	1					
Intrauterine Catheter Insertion	1	2				
	3	6				
Internal or External Monitoring - Uterine Contraction/Fetal Heart Tones	12	24	48	72	96	
	4	9	17	26	35	
Observation and Assessment, Second Stage Labor	1					
Routine Delivery Room Functions	17					
	19					
Fundus Massage.	1	3	4	6	9	12
	.5	1	1	2	3	4
Changing Perineal Pad	1	3	6	9	12	16
	.5	1	2	2	3	4
Perineal Suture Care.	2	3	4	6	8	10
	2	3	4	6	8	10
Postpartum Assessment	1	2	3			
	1	1	2			
Pitocin Induction	1					
Amniocentesis	2					
Non-Stress Test	10					
Oxytocin Challenge Test	8					
	20					

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Locate required nursing activity on the Obstetrical Nursing Activities Tasking Document and calculate total points based on the weighted score provided. Specify activity(s) and Total Score(s)).

THERAPEUTIC ACTIVITIES/MODALITIES (OTHER)

Nursing Activity	Frequency Rate	X	Score	=	Sub-Total
_____	_____	X	_____	=	_____
_____	_____	X	_____	=	_____
_____	_____	X	_____	=	_____

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APPENDIX C

Obstetric Patient Classification Instrument Instructional Information

OBSTETRICAL PATIENT CLASSIFICATION INSTRUMENT

INSTRUCTIONAL INFORMATION

1. Demographic Information:

a. Stamp the Obstetrical Patient Classification Instrument with the patient's Hospital Card in the space provided.

b. Record the date of the data collection period. Note that the rater completes this form at the end of the 24-hour period.

c. Record the rater's name in the appropriate blank.

d. Utilize the keypunch spaces 1 through 12 to collect data which best meets the requirements for your medical treatment facility. This demographic data could include the following:

- (1) Age of Patient
- (2) Sex of Patient
- (3) Day of the Week
- (4) SI or VSI Status
- (5) Clinical Service

2. The Obstetrical Patient Classification Instrument is an objective factor evaluation designed rating instrument. Extensive clinical observation combined with time and frequency studies were undertaken to identify those direct nursing care activities which most influence the total patient care requirements. These groupings of nursing activities, listed below, are considered to be Patient Care Indicators. Each nursing activity is operationally defined in the attached Tasking Document. The sum of the total points within each patient care indicator will become the Patient Care Indicator Score (PCIS).

- a. Hygiene
- b. Nutrition/Elimination
- c. Mobility/Exercise/Safety
- d. Psychological/Patient Teaching
- e. Vital Signs/Assessment/Diagnostic Tests
- f. Medication
- g. Gastrointestinal
- h. Respiratory
- i. Cardiovascular

- j. Skin
- k. Skeletal/Urological/Gynecological
- l. Obstetrical
- m. Other Therapeutic Activities/Modalities

3. The patient classification instrument is simple in that the professional nurse needs only to rate those nursing activities which are appropriate for the patient being rated. The nursing activities scored on the instrument must have been performed by nursing personnel or assistance provided to other staff members performing the activity. If the patient performs self-care activities, then score only those nursing activities performed by nursing personnel. Each patient needs only one rating for each 24-hour period. The rating of each patient must be completed at the end of the 24-hour period and must reflect the nursing care requirements for the preceding 24 hours. The normal rating period will be 0700 to 0700 hours, however, patients who are hospitalized less than 24 hours must also be rated. The ratings of these patients must be reflective of the time period that the patient was present within the hospital system.

4. The actual rating of each patient is accomplished by selecting the frequency rate for each nursing activity that was required during the rating period. The rating of the patient on the classification instrument is then accomplished by selecting the frequency rate from the options provided on the instrument. Select the frequency rate for each nursing activity that best meets the care requirements for the patient being rated. Each frequency rate has a corresponding point value (weighted score) as denoted in the blocks below each frequency rate.

EXAMPLE:

	FREQUENCY	1	2	3	6	9	12
Oral Hygiene	SCORE	1	2	3	6	10	13

This nursing activity with a frequency of "9" will receive a score of "10". Circle the appropriate score. After circling the score for each appropriate nursing activity, sum the scores within each Patient Care Indicator. Record this point value in the space provided as indicated in the following example:

EXAMPLE:

MEDICATION		FREQUENCY	1	2	3	4	6	9
Oral	SCORE	.5	.5	(1)	1	2	2	
Intramuscular		(.5)	1	1	2	2	4	
Subcutaneous		.5	.5	1	1	2	3	
Topical		.5	1	1	(2)	2	4	
Suppository, Rectal/Vaginal		.5	1	1				

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This Patient Care Indicator (Medication) consists of "3" oral, "1" intramuscular, and "4" topical for a total of "3.5" points.

5. If the patient requires a nursing activity that is not included on the Obstetrical Patient Classification Instrument, this additional procedure should be followed:

Locate the Nursing Activity Tasking Document (pages 15 thru 20) and obtain the score (points) for that activity. This point value is for a frequency of one, therefore, you must then multiply that figure by the appropriate frequency rate.

EXAMPLE:

SKIN:

WOUND IRRIGATION: Place equipment at bedside, remove soiled dressing, irrigate and cleanse site, apply dressing and then remove equipment from area.

4

Should the patient require two wound irrigations during the 24-hour rating period, multiply the frequency "2" times the score of "4". Indicate the activity(s) selected and the total point value clearly on the instrument (i.e., Wound Irrigation = 8).

6. The total PCIS points (Sum of the Patient Care Indicator Scores) determines the patient's Category of Care. Indicate the Total PCIS Points and circle the appropriate Category on page 1 of the Obstetrical Patient Classification Instrument.

EXAMPLE:

<u>TOTAL PCIS Points</u>	<u>WEIGHTED SCORE (Points)</u>	<u>CATEGORY (Circle One)</u>
	1 - 39	1
	40 - 79	2
<div style="border: 1px solid black; padding: 5px; display: inline-block;">79.5</div>	80 - 159	3
	160 - 239	4
	240 - 499	5

ROUND DOWN THE FRACTIONS: For example, anything less than "80" TOTAL PCIS Points will have the WEIGHTED SCORE of "79" and will remain CATEGORY "2".

7. The Obstetrical Patient Classification-Tabulation Form was developed for the recording of the Patient Care Indicator Scores (PCISs). These scores are to be recorded on this tabulation form along with the patient's name and age.

OBSTETRICAL PATIENT CLASSIFICATION TABULATION FORM

<u>TOTAL POINTS</u>	<u>HOURS OF CARE</u>	<u>CATEGORY OF CARE</u>	<u>NO. OF CASES</u>
1 - 39	<1 - 1	1	_____
40 - 79	2 - 3	2	_____
80 - 159	4 - 7	3	_____
160 - 239	8 - 11	4	_____
240 - 499	12 - 24	5	_____

			Patient Care Indicator Scores														
Nursing Unit	Date	Rater's Signature	Hygiene	Nutrition/ Elimination	Mobility/ Exercise/Safety	Psychological/ Patient Teaching	Vital Signs/ Assessment/ Diagnostic Tests	Medication	Gastrointestinal	Respiratory	Cardiovascular	Skin	Skeletal/ Urological/ Gynecological	Obstetrical	Other Therapeutic Activities/ Modalities	Total PCIS Score	Category of Care
Bed No.	Age	Name of Patient															

OBSTETRICAL NURSING ACTIVITIES TASKING DOCUMENT

Each operational definition includes; (1) Identify and screen the patient; (2) Explain the procedure to the patient; (3) Raise, lower, or adjust the bed before and after the nursing activity; and (4) Clean and straighten area.

HYGIENE:

SCORE

BATHING, COMPLETE: Place equipment at bedside; remove pajamas, bathe face, chest, abdomen and extremities; change water, bathe back, buttocks and perineal area; replace pajamas; and remove equipment from area. 7

BATHING, ASSIST WITH BACK AND LEGS: Place equipment at bedside; remove pajamas, allow for patient bathing as if in attendance; change water; then bathe back and lower extremities; replace pajamas and remove equipment from area. 4

BATHING, UTENSILS PROVIDED: Place equipment at bedside, allow time for patient to bathe and change pajamas; then remove equipment from area. 1

SITTING SHOWER/SHOWER WITH ASSISTANCE: Upon arrival in the shower room, assist patient in undressing, into shower, with bath and hair shampoo, assist in redressing, and back into the wheelchair. (Must remain with patient and provide assistance during the entire procedure.) 6

AM CARE: Place equipment at bedside, assist patient with bathing face, hands, and brushing teeth; then remove equipment from area. 2

AM CARE, PARTIAL: Place equipment at bedside, prepare bath water; put toothpaste on toothbrush; and remove equipment from area when patient has completed AM Care. 1

OR

AM CARE, UTENSILS PROVIDED: Place equipment at bedside, and then remove equipment from area when patient finishes AM Care.

ORAL HYGIENE: Place equipment at bedside, turn patient to his/her side, cleanse gums, teeth and mouth with applicators; then remove equipment from area. 1

SKIN CARE: Place equipment at bedside, cleanse and dry areas for special care, apply lotion, and then remove equipment from area. (Buttocks, hips, shoulders, heels.) 1

OR

BACK RUB: Place equipment at patient's bedside, remove pajama top, turn patient to expose back, rub back with lotion, replace pajama top, and then remove equipment from area.

PM CARE: Place equipment at bedside; bathe face and hands, brush teeth, and rub back; tighten and straighten bed linens; then remove equipment from area. 4

UNOCCUPIED BED: Place linen at bedside, remove soiled linen, place bottom sheet on mattress, then place on top sheet; change pillow cases; remove soiled linen from area. 2

HYGIENE (CONTIN.):

SCORE

OCCUPIED BED: Place linen at bedside; turn patient on side, roll linen to one side of bed, replace with clean linen, turn patient to freshly made side of bed, remove soiled linen and complete bed making; then remove soiled linen from bed. 3

CHANGING BED LINEN PROTECTOR/CHUX: Upon arrival at bedside, position patient, remove soiled chux, place clean chux under patient, straighten bed; then remove used chux from area. .5

NUTRITION/ELIMINATION:

FEEDING: Place meal tray at bedside; place towel or napkin as bib; prepare the food, feed patient slowly with appropriate utensils; then remove tray from area. 5

FLUID: Place fluids at bedside, place plastic drinking tube in liquid, give liquid to patient, then remove drinking cup and/or place within reach at patient's bedside. .5

SNACK: Place snack at bedside and, if required, prepare food for eating. .5

SERVING MEAL TRAY, PREPARATION REQUIRED: Place tray at bedside, prepare food and utensils, and prepare towel or napkin as bib. 1

SERVING MEAL TRAY, NO PREPARATION REQUIRED: Place tray at bedside. .5

MEASURING & RECORDING INTAKE: Place calibrated cylinder/container at bedside; measure or calculate fluids and record amount on Intake and Output Record; then remove used equipment from area. .5

MEASURING & RECORDING OUTPUT - URINE: Place calibrated cylinder at bedside; measure or calculate volume, record amount on Intake and Output Record; then remove equipment from area. .5

OR

MEASURING & RECORDING OUTPUT - VOMITUS: Remove emesis from patient's bedside, measure vomitus in calibrated cylinder, record amount on Intake and Output Record.

OR

MEASURING & RECORDING OUTPUT - DRAINAGE BOTTLES, ALL TYPES: Place calibrated cylinder at bedside, pour contents from drainage bottle into calibrated cylinder, measure or calculate volume, replace drainage bottle, record amount on Intake and Output Record, and then remove equipment from area.

GIVING A BEDPAN: Place bedpan at bedside, place patient on bedpan, provide toilet tissue, remove patient from bedpan, cover bedpan, and remove from area. 1

MOBILITY/EXERCISE/SAFETY:

CHANGING PATIENT'S POSITION IN BED: Remove support pillows, reposition patient; apply support pillows. 1

MOBILITY/SAFETY/EXERCISE (CONTIN.):

SCORE

ADJUSTING POSITION OF BED: Raise, lower or adjust position of bed, .5

MOBILITY - AMBULATING FIRST TIME: Assist patient into sitting position on side of bed; then into upright standing position; walk with patient; then assist patient back into bed. 2

OR

MOBILITY - ASSISTANCE WHILE WALKING: Assist patient into a sitting position on side of bed, then into an upright standing position, then with ambulation, and then back into bed.

MOBILITY - BED TO CHAIR: Position chair/wheelchair at bedside, assist patient into sitting position, slowly bring patient into an upright standing position; then assist into chair and assist back to bed. 2

MOBILITY - BED TO STRETCHER: Place stretcher at bedside, transfer patient to stretcher, fasten safety straps or adjust side rail, remove stretcher from bedside. 2

MOBILITY - BED TO FLOOR: Assist patient into sitting position on side of bed, then slowly bring patient into an upright position; then assist back into bed. .5

OR

MOBILITY - SITTING ON SIDE OF BED: Assist patient into sitting position on side of bed; then assist patient back into supine position.

EXERCISE - ACTIVE: Supervise the patient as he/she actively performs the prescribed exercise program. 2

ADJUSTING SIDE RAIL: Changing position of side rails, i.e., up, down, or removal. .5

PSYCHOLOGICAL/PATIENT TEACHING:

ORIENTATION TO CLINICAL UNIT: Instructing on the use of the nurse's call system, the hospital bed, and the layout of the physical facility. 2

EXPLANATION OF PROCEDURES AND TESTS: Instructing patient on what he/she can expect from procedure/test, what the health care personnel will be doing during the procedure/test, and why such procedure/test is being done. .5

ANSWERING PATIENT'S QUESTION: Time spent in answering patient's questions or in response to the patient call system. .5

VISITING WITH PATIENT/PURPOSEFUL INTERACTION: Time spent at patient's bedside without providing any direct physical care to patient which is not in response to patient call system or patient questions. 1

TEACHING - MEDICATION ADMINISTRATION: Upon arrival at bedside, provide instruction on dosage, route, and specific drug-related information. 7

TEACHING - URINE TESTING: Place equipment at bedside, provide instructions on the purpose, and technique for the urine testing. .5

PSYCHOLOGICAL/PATIENT TEACHING (CONTIN.):

SCORE

TEACHING - DISEASE/CONDITION RELATED: Upon arrival at bedside, provide instruction on the nature and scope of the disease process, special care requirements, limitations and/or restrictions related to disease/illness, 2

TEACHING - BLOW BOTTLES/INCENTIVE SPIROMETER: Place equipment at bedside, instruct patient on the purpose and use of equipment. 1

TEACHING - DIETARY EXPLANATION: Upon arrival at bedside, provide instruction on dietary requirements/restrictions. 1

TEACHING - PREOPERATIVE : Upon arrival at bedside, provide instruction on preoperative and postoperative requirements. (Skin preparation, cough and deep breathe, ankle exercises and position change.) 3

TEACHING - DIAGNOSTIC TEST: Upon arrival at bedside, provide information on the purpose and requirements for the diagnostic test. .5

TEACHING - PERINEAL SUTURE CARE: Place equipment at bedside, instruct patient on technique of perineal care, i.e., cleanse area with antiseptic solution, irrigate with water, dry suture area. Then apply heat lamp to suture line. 1

TEACHING - BREAST FEEDING: Provide instructions on the technique of breast feeding; observe mother during the feeding process to assess proper technique. 4

TEACHING - BOTTLE FEEDING: Upon arrival at bedside, provide instructions on the technique of bottle feeding; observe mother during the feeding process to assess proper technique. 3

TEACHING - BREAST CARE: Upon arrival at bedside, instruct patient on how to cleanse area around nipple, the need for wearing a support bra, and how to recognize minor signs and symptoms of problems that may occur with breast feeding. 1

VITAL SIGNS/ASSESSMENT/DIAGNOSTIC TESTS:

BLOOD PRESSURE, MANUAL: Place equipment at bedside, place cuff around extremity, position stethoscope, measure blood pressure, remove cuff, record results; remove equipment from area. .5

ORAL TEMPERATURE, PULSE AND RESPIRATIONS: Place equipment at bedside, position temperature probe or thermometer. Place fingers over radial artery pulse and count rate. Count respiratory rate while fingers are placed over radial artery pulse. Remove fingers from radial artery pulse rate, record results of measurements, and then remove equipment from area. .5

PULSE - APICAL: Place equipment at bedside, place stethoscope over apex of heart and count rate, remove stethoscope, record pulse rate, and then remove equipment from area. .5

PULSE - RADIAL/BRACHIAL: Place fingers over pulse and count rate, remove fingers from pulse area and record results. .5

VITAL SIGNS/ASSESSMENT/DIAGNOSTIC TESTS (CONTIN.):

SCORE

TEMPERATURE - ORAL, ELECTRONIC/MERCURY: Place equipment at bedside, place probe or thermometer under tongue, measure temperature, remove temperature probe or thermometer, record and then remove equipment from area.

.5

OR

TEMPERATURE - RECTAL, ELECTRONIC/MERCURY: Place equipment at bedside, adjust clothing, insert temperature probe or thermometer in anus, measure temperature, remove temperature probe or thermometer, record, and then remove equipment from area.

OR

TEMPERATURE - AXILLARY, ELECTRONIC/MERCURY: Place equipment at bedside, place temperature probe or thermometer in axillary area, measure temperature, remove temperature probe or thermometer, record and then remove equipment from area.

RESPIRATIONS: Count respiratory rate, and/or count and calculate rate, and then record.

.5

PULMONARY ASSESSMENT: Upon arrival initiate assessment by auscultation of the lungs, and/or percussion of the chest wall over the involved areas. Assess symmetry of chest and determine if respiratory movement is abdominal or thoracic.

.5

BOWEL SOUND ASSESSMENT: Upon arrival at bedside, utilize a stethoscope to assess status of bowel sounds, then remove equipment from area.

.5

AMBULATORY WEIGHT: Place equipment at bedside, assist patient onto the scales, balance scales, read and record weight reading, assist patient off the scales, and then remove equipment from area.

.5

ORIENTATION: Upon arrival at bedside, make inquiries within the framework of interviewing that will give information about patient's orientation for time, place and person, and then record results.

.5

MENTAL ALERTNESS: Upon arrival at bedside, make inquiries within the framework of interviewing that will give information about the patient's orientation, memory, intellectual performance, and judgment; then record results.

.5

MOTOR/SENSORY TESTING: Upon arrival at bedside, assess extremities for sensation awareness and muscle strength.

.5

PUPIL REFLEXES: Place equipment at bedside, adjust room lighting, assess pupillary reflexes with flashlight and remove equipment from area.

.5

URINE TESTING - PROTEIN: Upon arrival at bedside, collect urine sample, utilizing test strip assess for albumin, compare test strip against standard, read and record results; then remove used equipment from area.

.5

OR

URINE TESTING - SPECIFIC GRAVITY: Place equipment at bedside, collect urine sample and utilizing a urometer, measure specific gravity, record results, and then remove equipment from area.

VITAL SIGNS/ASSESSMENT/DIAGNOSTIC TESTS (CONTIN.):

SCORE

OR

URINE TESTING - SUGAR AND ACETONE: Place equipment at bedside, collect urine sample, measure sugar and acetone, record results, then remove equipment from area.

SITUATIONAL OBSERVATION: Assignment of one member of the nursing team to observe and provide nursing care to the patient during a specific activity. Observation required only during the specific activity. This might include, but is not limited to, transport within or without the hospital when the patient is not stable enough to be left without nursing support. 9

MEDICATION:

ORAL: Upon arrival at bedside, obtain a glass of water and administer the oral medication. .5

INTRAMUSCULAR: Place equipment at bedside, locate site for injection, administer medication, and then remove equipment from area. .5

SUBCUTANEOUS: Place equipment at bedside, locate site for injection, administer medication, and then remove equipment from area. .5

TOPICAL: Place equipment at bedside, locate and expose site for topical application of medication, apply medication, and then remove equipment from area. .5

SUPPOSITORY, RECTAL/VAGINAL: Place equipment at bedside, prepare and administer suppository; then remove equipment from area. .5

GASTROINTESTINAL:

NASOGASTRIC TUBE - INSERTION: Place equipment at bedside, secure towel around patient's neck, give patient glass of water, instruct patient on how to swallow tube, lubricate tube, insert tube, assess for placement, tape in position, then remove equipment from area/or when non-responsive omit glass of water and instructions. 3

NASOGASTRIC TUBE - REMOVAL: Place towel around patient's neck, position patient, remove tape, clamp tube and remove tubing, and then remove equipment from area. .5

NASOGASTRIC TUBE - IRRIGATION: Place irrigation solution at bedside, unclamp or disconnect tube, irrigate tubing with asepto syringe, reclamp or reconnect tubing; then remove equipment from area. 1

OR

NASOGASTRIC TUBE - INSTILLATION: Place medication and/or normal saline at bedside, unclamp or disconnect tube, instill solution with asepto syringe, reclamp or reconnect tubing; then remove equipment from area.

ENEMA - CLEANSING: Place equipment at bedside, position patient, lubricate tubing, insert rectal tube, administer solution; then remove equipment from area. 2

ENEMA - RETENTION: Place equipment at bedside, position patient, administer solution; then remove equipment from area. .5

RESPIRATORY:

SCORE

OXYGEN ADMINISTRATION - RESPIRATOR: Upon arrival at bedside assess and/or regulate oxygen and ventilator pressures, assess all tubing for patency and collection of fluids within tubing, assess fluid level in water vapor container, and then assess proper position of alarms.

.5

OR

OXYGEN ADMINISTRATION - MASK: Place equipment at bedside, turn on oxygen, fit the mask over mouth and nose, adjust headband, evaluate fit and patient's adjustment to the equipment, and regulate oxygen flow rate,

OR

OXYGEN ADMINISTRATION - PRONGS: Place equipment at bedside, fit nasal prongs and adjust headband, regulate oxygen rate; evaluate patient's adjustment to oxygen and equipment.

COUGH AND DEEP BREATHE: Upon arrival at bedside, have patient cough and deep breathe, if cough productive then dispose of sputum.

1

BLOW BOTTLES: Place equipment at bedside, assist with placement of bottles, have patient perform procedure; then locate equipment at bedside for next treatment.

1

OR

INCENTIVE SPIROMETER: Place spirometer at bedside, assist patient during the procedure to determine proper usage of spirometer, and then remove or replace to storage area at bedside.

CARDIOVASCULAR:

VENIPUNCTURE - BLOOD SAMPLE: Place equipment at bedside. Apply tourniquet to extremity, cleanse site, perform venipuncture and withdraw blood sample, and then apply pressure to puncture site. Apply labels on blood tubes and remove equipment from area.

1

OR

VENIPUNCTURE - BLOOD CULTURE: Place equipment at bedside, apply tourniquet to extremity, clean site, perform venipuncture and withdraw blood sample, and then apply pressure to puncture site. Apply labels on blood culture bottle and remove equipment from area.

INTRAVENOUS INFUSION - INITIATING: Place equipment at bedside, apply tourniquet to extremity, cleanse site, perform venipuncture and connect IV tubing, apply ointment and dressing, and tape securely. Calculate and regulate flow rate, record on Intake and Output Record, and remove equipment from area.

3

INTRAVENOUS INFUSION - FLOW RATE: Upon arrival at bedside, calculate and adjust flow rate as specified.

.5

INTRAVENOUS INFUSION - CHANGING IV BOTTLES: Place equipment at bedside, remove used IV container and replace with new IV container, calculate and regulate flow rate, record on I&O record, and remove equipment from area.

.5

INTRAVENOUS INFUSION - IV PUSH MEDICATION: Place equipment at bedside, select site for injection of solution utilizing existing system, administer IV solution, and remove equipment from area.

.5

OR

INTRAVENOUS INFUSION - PIGGY-BACK MEDICATION: Place equipment at bedside, select site for administration of solution utilizing existing systems, record on Intake and Output Record, and remove equipment from area.

CARDIOVASCULAR (CONTIN.):

SCORE

INTRAVENOUS INFUSION - IV CATHETER CARE: Place equipment at bedside, remove dressing from IV catheter site, cleanse skin, apply ointment, replace dressing and then date, time and initial the dressing, change IV tubing, and remove equipment from area. 3

INTRAVENOUS INFUSION - INFUSION PUMP SETUP: Place equipment at bedside, set-up IV tubing and adjust flow rate dial. Record on I&O Record and remove used equipment from area. (If existing IV container present then remove and proceed as defined.) 1

INTRAVENOUS INFUSION - PLATELETS/PLASMA: Place equipment at bedside, connect to present intravenous system, record on I&O Record; and remove used equipment from area. 1

OR

INTRAVENOUS INFUSION - BLOOD: Place equipment at bedside, assure correct transfusion, etc., connect to present intravenous system, record on I&O Record, and remove equipment from area.

INTRAVENOUS/ARTERIAL LINE - TERMINATION: Place equipment at bedside, remove dressing and terminate IV or arterial catheter/needle, apply pressure to site, and record on I&O Record if appropriate. Remove equipment from area. 1

ELASTIC STOCKINGS: Place stockings at bedside. Expose lower extremities, and then put elastic stockings on lower extremities. 1

SKIN:

SURGICAL PREP, LOCAL: Place equipment at bedside, prepare skin for prep, shave area specified, and then remove used equipment from area. 4

SURGICAL PREP, 3-WAY: Place equipment at bedside, prepare skin for prep, shave area specified, and then remove used equipment from bedside. Instruct patient to shower with surgical soap three times. 6

SUTURE/SKIN CLIP REMOVAL, \geq 15: Place equipment at bedside, remove dressing if required, remove sutures, and then remove equipment from area. 5

SUTURE/SKIN CLIP REMOVAL, $<$ 15: Place equipment at bedside, remove dressing if required, remove sutures or skin clips, and then remove equipment from area. 2

SMALL DRESSING CHANGE, $<$ 4"x 8": Place equipment at bedside, remove soiled dressing, cleanse skin, apply dressing to site, and then remove equipment from area. 2

WOUND CULTURE: Place equipment at bedside, remove soiled dressing, obtain culture from site, label culture, apply new dressing, and then remove equipment from area. 1

SITZ BATH: Prepare sitz bath equipment, assist patient into sitz bathtub, assist patient from the tub and towel dry, and then assist patient back into bed. 4

<u>SKIN (CONTIN.):</u>	<u>SCORE</u>
<u>K-PAD APPLICATION:</u> Upon arrival at bedside, apply K-pad to prescribed area, then depart from area.	.5
<u>HEAT LAMP APPLICATION:</u> Place or position lamp at bedside, expose site, and apply heat lamp.	.5
<u>SKELETAL/UROLOGICAL/GYNECOLOGICAL:</u>	
<u>ICE PACK:</u> Place ice bag at bedside, remove old ice bag and replace with new ice bag, secure ice bag in place; then remove equipment from area.	.5
<u>EXTREMITY ELEVATION:</u> Place equipment at bedside, elevate extremity through use of pillows, bed adjustments and/or sling attachments.	.5
<u>CATHETERIZATION - FOLEY:</u> Place equipment at bedside, prepare patient and insert Foley Catheter, inflate balloon, tape catheter in position, connect to urinary drainage bag; then remove used equipment from area.	2
OR	
<u>CATHETERIZATION - STRAIGHT:</u> Place equipment at bedside, prepare patient and insert catheter, empty bladder and remove straight catheter; then remove used equipment from area.	
<u>FOLEY CATHETER CARE:</u> Place equipment at bedside, cleanse area around catheter, apply ointment, and then remove used equipment from area.	1
OR	
<u>FOLEY CATHETER REMOVAL:</u> Place equipment at bedside, expose catheter and drainage system, deflate Foley balloon and remove Foley Catheter. Measure urine and record on I&O Record; then remove used equipment from area.	
<u>URINE SPECIMEN - ROUTINE:</u> Place equipment at bedside, instruct patient on how to collect specimen, label specimen, and then remove specimen from area.	.5
OR	
<u>URINE SPECIMEN - CLEAN CATCH/FOLEY:</u> Place equipment at bedside, instruct patient on how to collect specimen, label specimen, and then remove specimen from area.	
<u>PERINEAL CARE:</u> Place equipment at bedside, prepare and cleanse perineal area (use bedpan with treatment solution/or bathe area); then remove equipment from area.	1
<u>VAGINAL/PELVIC EXAMINATION:</u> Assist patient onto examination table, position patient, set-up equipment and assist physician with the procedure; then assist patient in getting off the examination table.	2
<u>OBSTETRICAL:</u>	
<u>LABOR ROOM EXAMINATION AND PREPARATION, ROUTINE:</u> When patient arrives in the examination room, the following nursing activities are appropriate: urine sample analysis for protein; obtain weight; position on examination table; measure and record vital signs and fetal heart tones; perform or assist with vaginal examination; then prep as required and administer enema (nursing personnel must remain in constant attendance).	9

OBSTETRICAL (CONTIN.):

SCORE

FETAL HEART TONES, MANUAL: Upon arrival at bedside, expose abdominal area, assess fetal heart tones with fetoscope, record FHT's, then remove equipment from area. .5

OR

FETAL HEART TONES, DOPPLER: Upon arrival at bedside, expose abdominal area, assess fetal heart ones utilizing the doptone, record results; then remove equipment from area.

DILITATION AND EFFACEMENT ASSESSMENT: Set-up equipment at bedside, position patient for procedure, perform vaginal examination for assessment of dilitation level and effacement; then remove used equipment from area. .5

OR

DILITATION AND EFFACEMENT ASSESSMENT: Set-up equipment at bedside, position patient fro procedure, assist physician with the examination; then remove used equipment from area.

SUPPORT DURING CONTRACTION: Upon arrival at bedside, verbally reassure patient, provide touch support as indicated, encourage and demonstrate proper breathing and then depart patient's area. 1

MANUAL CONTRACTION ASSESSMENT: Upon arrival at bedside, expose abdominal area, place hand over uterus and assess strength and duration of uterine contraction. .5

ULTRASONIC TRANSDUCER - APPLICATION: Upon arrival at bedside, position patient, expose abdominal area, locate fetal heart tones, apply ultrasonic transducer, connect to monitoring equipment, assess status of fetal heart tones; then depart patient's area. 1

TOCOTRANSDUCER - APPLICATION: Upon arrival at bedside, position patient, expose abdominal area, apply tocotransducer, connect to monitoring equipment, assess status of contraction; then depart patient's area. 1

ADJUST ULTRASONIC TRANSDUCER/TOCOTRANSDUCER: Upon arrival at bedside, adjust ultrasonic transducer and/or tocotransducer. 1

AMNIOTOMY: Set-up equipment at bedside, position patient for procedure, assess fetal heart rate, assess patient's vital signs, assist physician with procedure; then remove used equipment from area. 1

FETAL ELECTRODE INSERTION: Set-up equipment at bedside, position patient, assist physician with procedure, secure monitor leads to patient's lower extremity, connect equipment, assess and record fetal heart rate; then remove used equipment from area. 1

INTRAUTERINE CATHETER INSERTION: Set-up equipment at bedside, position patient, assist physician with procedure, connect monitoring equipment, flush catheter with water; then remove used equipment from area. 3

INTERNAL OR EXTERNAL MONITORING - UTERINE CONTRACTION/FETAL HEART TONES: Upon arrival at bedside, assess and calculate the amplitude and duration of the contractions, then assess fetal heart tones, and record FHT's and contraction findings. .5

OBSTETRICAL (CONTIN.):

SCORE

OBSERVATION AND ASSESSMENT, SECOND STAGE OF LABOR: When complete dilatation of the cervix occurs, a member of the nursing staff remains in constant attendance to evaluate amplitude and duration of each contraction, assess fetal heart tones and to encourage proper breathing and bearing down efforts (labor room only). 17

ROUTINE DELIVERY ROOM FUNCTIONS: Upon arrival in delivery room, assist patient onto table and position, set-up delivery trays, perform surgical scrub, assess status of mother and fetus, provide assistance to physician and patient during the delivery room process. Establish the airway, determine apgar score, obtain cord blood, clamp umbilical cord, provide prophylactic eye care, stabilize neonate's temperature, administer vitamin K, and then complete identification of neonate. Assist physician with delivery of placenta, massage fundus and determine level of fundus, administer medications to patient, complete delivery records, reposition patient, and transport to stretcher and transport to recovery room. 19

FUNDUS MASSAGE: Upon arrival at bedside, expose patient's lower abdominal area, massage fundus and assess height of uterus; then record. .5

CHANGING PERINEAL PAD: Place supplies at bedside, assess amount of bleeding, change perineal pads; then remove used supplies from area. .5

PERINEAL SUTURE CARE: Cleanse area with antiseptic solution, irrigate with water, dry suture area, and apply heat lamp to suture line. 1

POST PARTUM ASSESSMENT: Upon arrival at bedside complete the following: (a) Initiate assessment of breast by inspection and palpation of each breast, assess for contour, engorgement, tenderness, nodules, venous patterns and color; (b) Initiate assessment of uterus by inspection and palpation, assess for involution, tone, contour and location; (c) Initiate bladder assessment by eliciting feedback, inspection and palpation, assess for distention, frequency of urination and pain on urination; (d) Initiate episiotomy assessment by assisting patient into a lateral position and by inspection of perineal/rectal area, assess for inflammation, infection and hemorrhoids; (e) Initiate assessment of bowel function by eliciting feedback for bowel movements and adequacy of diet and; (f) Initiate assessment for Homan's Sign by assisting patient to supine position and then press on patient's knee and flex patient's foot. 1

PITOCIN INDUCTION: Place equipment at bedside, assess fetal heart tones, assess BP, P&R, assist physician with initiation and regulation of pitocin infusion, and then place hand over the abdomen until the patient gets a regular contraction. (Repeat FHT; BP, P&R as indicated during the procedure.) 2

AMNIOCENTESIS: Set-up equipment at bedside, assess vital signs of patient, assess fetal heart tones, assist physician with procedure, label specimens; then remove equipment from area. 10

NON-STRESS TEST: Set-up equipment at bedside, assess baseline vital signs and fetal heart tones; monitor and assess fetal heart tones, fetal movement, and uterine activity. 8

OXYTOCIN CHALLENGE TEST: Set-up equipment at bedside, assess baseline vital signs and fetal heart rate, set-up and initiate intravenous infusion, set-up Harvard infusion pump, regulate flow rate on Harvard infusion pump, assess status of patient (TRP & BP) and fetus(FHT's). 20

OTHER NURSING ACTIVITIES WHICH MAY BE UTILIZED TO DETERMINE CATEGORY OF CARE:

HYGIENE:

SCORE

NAIL CARE: Place equipment at bedside, wash hands/feet and nails, trim and clean finger/toe nails, remove equipment from area.

1

SHAMPOO: Place equipment at bedside; position patient, wet hair and apply shampoo, lather and rinse, dry hair with towel, comb and brush hair; and then remove equipment from area.

3

CHANGING TOP SHEET: Place linen at bedside, remove top sheet, replace with clean sheet; then remove soiled linen from area.

.5

CHANGING BOTTOM SHEET: Place linen at bedside, remove bottom sheet, replace with clean sheet, straighten top sheet; then remove soiled linen from area.

1

NUTRITION/ELIMINATION:

SPECIAL FEEDING - HYPERALIMENTATION, INTRAVENOUS: Determine calibration of infusion equipment. Place hyperalimentation fluids at bedside, exchange filter and tubing, establish scheduled flow rate, record, and then remove equipment from area.

2

SPECIAL FEEDING - NASOGASTRIC: Place feeding at bedside, unclamp tube, assess placement of tube, administer tube feeding, flush tube with water, clamp tube, record, and then remove feeding equipment from area.

1

SPECIAL FEEDING - NASOGASTRIC, CONTINUOUS WITH INFUSION PUMP: Place equipment at bedside, remove and/or position feeding bottle, connect to feeding tube, set-up through flow rate adjuster of equipment, establish flow rate, record on Intake and Output Record; then remove equipment from area.

1

SPECIAL FEEDING - NASOGASTRIC, CONTINUOUS FEEDING WITH GASTRIC FEEDING EQUIPMENT: Place equipment at bedside; connect to feeding tube/nasogastric tube, adjust flow rate, record on Intake and Output Record; then remove equipment from area.

1

MEASURING AND RECORDING OUTPUT - LIQUID FECES: Remove bedpan from patient's bedside; measure feces in calibrated cylinder, record amount on Intake and Output Record.

.5

INCONTINENT CARE: Place equipment at patient's bedside, bathe buttocks, perineum and thighs; change bedding; then remove equipment and soiled linen from area.

2

MOBILITY/EXERCISE/SAFETY:

FOWLERS/TRENDELENBERG POSITION: Upon arrival at bedside, position bed in either Fowlers or Trendelenberg position, assess comfort of patient in this position, and then depart from area.

.5

MOBILITY/EXERCISE/SAFETY (CONTIN.):

SCORE

MOBILITY - BEDSIDE COMMODE: Position commode chair next to bedside, assist patient into sitting position, slowly bring patient into an upright standing position, assist patient onto commode chair, and then assist patient back into bed.

1

EXERCISE - PASSIVE: Manually moving patient's extremities through the prescribed exercise program.

2

VITAL SIGNS/ASSESSMENT/DIAGNOSTIC TESTS:

PULSE - DOPPLER: Place equipment at bedside, place sensor over pulse area, assess and record pulse rate; then remove equipment from area (types of equipment may vary).

1

PULSE - PEDAL/FEMORAL/POPITEAL: Place fingers on the artery pulse and count rate. Remove fingers from pulse area and record results.

.5

BED SCALE WEIGHT: Place equipment at bedside, assist patient onto the scales, read and record weight reading, assist patient in getting off the scales, and then remove equipment from area.

2

ABDOMINAL GIRTH MEASUREMENT: Upon arrival at bedside, expose abdominal area, measure girth, record and then depart from area.

1

EXTREMITY CIRCUMFERENCE MEASUREMENT: Upon arrival at bedside, place tape measure around the extremity/extremities and assess measurement; then record results.

.5

HEART SOUNDS ASSESSMENT: Place stethoscope at bedside, arrange pajamas for visual access of chest, assess and record findings; remove stethoscope from area.

.5

MONITORING LEADS APPLICATION/EXCHANGE: Place equipment at bedside, exchange leads/or apply new leads, then remove equipment from area.

1

ADJUSTING CARDIAC MONITOR/CONNECTING LEADS/RESET ALARM: Upon arrival at bedside, adjust cardiac monitor, connect leads or reset alarm; then depart the area.

.5

RHYTHM STRIP - MONITOR: Obtain 20 second strip, record name, date and time, then file for future use.

.5

RHYTHM STRIP MEASUREMENTS: Upon obtaining the rhythm strip, measure P-R interval, S-T segment, and assess for arrhythmic pattern; record results.

.5

RHYTHM STRIP - ECG MACHINE: Place equipment at bedside, prepare equipment for use, apply limb leads, obtain 20 second strip, record name, date and time, remove limb leads; then remove equipment from area.

3

12 LEAD ECG: Place equipment at bedside, connect leads to patient and obtain ECG. Record name, date and time on ECG. Remove leads and clean skin, then remove equipment from area.

3

<u>VITAL SIGNS/ASSESSMENT/DIAGNOSTIC TESTS (CONTIN.);</u>	<u>SCORE</u>
<u>VITAL CAPACITY:</u> Place equipment at bedside. Utilizing the spirometer determine the respiration reserve volume, the tidal volume and the expiratory reserve volume. Calculat and record results and then remove equipment from area.	2
<u>SENSORY DISCRIMINATION:</u> The utilization of those approaches which will indicate that the examiner is screening for pain, vibration, light touch, and stereognosis intact, and then record results.	.5
<u>COLLECTION OF FECES SPECIMEN FOR ROUTINE O&P AND CULTURE:</u> Upon obtaining a feces sample, place sample in collection container, label, and then remove from area.	.5
<u>HEMATOCRIT:</u> Upon obtaining the blood sample, process, assess and record the results.	1
<u>GUAIAAC TESTING - FECES/VOMITUS/GI DRAINAGE:</u> Upon obtaining sample, test sample for guaiac, record results, and then remove from area.	.5
<u>LUMBAR PUNCTURE:</u> Place equipment at bedside, assist physician with procedure, and then remove equipment from area.	7
<u>GASTROINTESTINAL:</u>	
<u>RECTAL TUBE INSERTION:</u> Place equipment at bedside, insert rectal tube, connect to drainage bag; then remove used equipment from area.	1
<u>RECTAL TUBE REMOVAL:</u> Place equipment at bedside, remove rectal tube and drainage bag; then remove used equipment from area.	1
<u>FECAL IMPACTION - ASSESSMENT/REMOVAL:</u> Upon arrival at bedside, position patient, put on rubber gloves, assess for fecal impaction and then manually break up fecal mass; then remove used equipment from area.	1
<u>RESPIRATORY:</u>	
<u>SUCTIONING - ORAL:</u> Place equipment or set-up equipment at bedside, suction oral cavity with suction catheter/or oral suction tip, flush catheter before and after each aspiration, replace used equipment, and remove used equipment from area.	.5
<u>IPPB TREATMENT:</u> Place equipment in position of use, assist patient during the treatment, and replace equipment after use.	3
<u>CHEST PULMONARY THERAPY - FRAPPAGE WITH POSTURAL DRAINAGE:</u> Upon arrival at bedside, position patient, initiate treatment by auscultation of lung fields. Perform percussion to each involved segment followed by vibration.	1
<u>POSITIONING FOR X-RAY:</u> Upon arrival at bedside, assist with positioning of x-ray film; then assist with removal of exposed film.	1
<u>RESPIRATORY RESUSCITATION:</u> Place equipment at bedside. Check all equipment, assist physician with insertion of endotracheal/tracheostomy tube, bag breathe as indicated, connect respirator; then remove equipment from area..	11

RESPIRATORY (CONTIN.):

SCORE

INTUBATION: Place equipment at bedside, assist physician during the intubation process, tape endotracheal tube in place and remove equipment from area.

6

CARDIOVASCULAR:

ARTERIAL PUNCTURE - BLOOD GASES: Place equipment at bedside, locate arterial puncture site, perform puncture and draw blood, and then place sample on ice. Apply pressure to puncture site; then label sample and remove equipment from area.

2

ARTERIAL LINE - INITIATION: Place equipment at bedside, assist physician with the procedure as required, connect to arterial line set-up, assess status of arterial line; then remove equipment from area.

14

ARTERIAL LINE - ARTERIAL LINE SET-UP: Place equipment at bedside, set-up transducer tray, IV solution and cardiac monitor. Assist physician with insertion of arterial catheter. Calibrate the cardiac monitor, and measure the transducer current with a mercury sphygmomanometer. Remove equipment from area.

6

INTRAVENOUS/ARTERIAL LINE - BLOOD SAMPLE: Place equipment at bedside, clear system, obtain blood sample through stopcock, flush system, label samples, and then remove equipment from area.

1

ARTERIAL LINE - TRANSDUCER EXCHANGE: Place equipment at bedside, set-up transducer tray and IV solution, calibrate the cardiac monitor, and measure the transducer current with a mercury sphygmomanometer. Remove equipment from area.

5

SURGICAL INTRAVENOUS INITIATION, CUT DOWN: Place equipment at bedside, assist physician with the procedure as required, connect to intravenous line set-up, assess status of intravenous line; then remove equipment from area.

15

CARDIOPULMONARY RESUSCITATION: Upon arrival at bedside, perform any or all aspects of cardiopulmonary resuscitation.

21

HYPOTHERMIA/HYPERTHERMIA TREATMENT: Place equipment at bedside, apply blankets, assess status of equipment. Insert rectal temperature probe for monitoring, and then remove unused equipment from area.

2

ACE BANDAGE: Place equipment at bedside, wrap extremity securely with ace bandage and secure in place with tape or metal hooks.

1

SKIN:

VULVAR/ANAL AREA PREP: Set-up equipment at bedside, position patient, cleanse and lather area, shave area, rinse and dry shaved area; then remove equipment from area.

1

COLD COMPRESS: Place equipment at bedside, apply cold compress to site and then remove equipment from area.

3

<u>SKIN (CONTIN.):</u>	<u>SCORE</u>
<u>HOT COMPRESS:</u> Place equipment at bedside, apply hot compress to site, and then remove equipment from area.	1
<u>REINFORCING DRESSING:</u> Place equipment at bedside, apply dressing to present dressing for reinforcement, and then remove equipment from area.	1
<u>LARGE DRESSING CHANGE, ≥ 4"x 8":</u> Place equipment at bedside, remove soiled dressing, cleanse skin, apply dressing to site, and then remove equipment from area.	4
OR	
<u>WOUND IRRIGATION:</u> Place equipment at bedside, remove soiled dressing, irrigate and cleanse site, apply dressing and then remove equipment from area.	
<u>SOAKING HAND:</u> Place equipment at bedside, soak hand in solution basin, remove and towel dry hand, and then remove equipment from area.	3
<u>SOAKING FEET:</u> Place equipment at bedside, soak foot/feet in solution basin, remove and towel dry foot/feet, and remove equipment from area.	2
<u>AIR FLOATATION/ALTERNATING PRESSURE MATTRESS:</u> Place equipment at bedside, apply air floatation or alternating pressure mattress to hospital bed. (Turn patient as appropriate if application is made with patient in the bed.) Remove soiled linens/equipment from area.	2
<u>ISOLATION, GOWNING & GLOVING:</u> Upon arrival at isolation area, wash hands, put on isolation gown, mask and gloves, or when departing the isolation area, remove isolation gown, mask and gloves; then wash hands.	.5
<u>DEATH CARE:</u> Place equipment at bedside, prepare patient and cover with shroud. (Do not measure the time required for the family to view the body after death.)	8
<u>EENT:</u>	
<u>EYE CARE:</u> Place equipment at bedside, cleanse eyes and apply solution/ointment as prescribed. Apply eye patch and then remove equipment from area.	.5
<u>INSTILLATION OF DROPS - EYE:</u> Upon arrival at bedside, position patient, instill eye drops, and then remove equipment from area.	.5
<u>INSTILLATION OF DROPS - EAR:</u> Upon arrival at bedside, position patient, instill ear drops, and then remove equipment from area.	.5
<u>INSTILLATION OF DROPS - NOSE:</u> Upon arrival at bedside, position patient, instill nose drops, and then remove equipment from area.	.5
<u>CULTURE - NOSE:</u> Place equipment at bedside, position patient; obtain nose culture, label culture, and remove equipment from area.	.5
<u>CULTURE - THROAT:</u> Place equipment at bedside, position patient, obtain throat culture, label culture, and remove equipment from area.	.5
<u>CULTURE - SPUTUM:</u> Place equipment at bedside, position patient, have patient cough to obtain sputum, apply label to sputum specimen, and then remove equipment from area.	1

NEUROLOGICAL/SKELETAL/UROLOGICAL/GYNECOLOGICAL:

SCORE

SEIZURE CARE: Upon arrival in the patient's area, place padded tongue blade in position, and support patient during the seizure, 2

FOOT BOARD: Place equipment at bedside, position foot board into place and then align and position the extremities. .5

CIRCULATION CHECK: Upon arrival at bedside check extremity for swelling, numbness, and tingling, evaluate temperature and color of the skin, and then assess the patient's ability to move the part. .5

BLADDER IRRIGATION: Place equipment at bedside, set up equipment and irrigate bladder; then remove equipment from area. 1

URINARY BLADDER TRAINING: Upon arrival at bedside, clamp/unclamp catheter, record time and urine output if appropriate. .5

DOUCHE: Place equipment at bedside, position patient on bedpan, administer douching solution, remove bedpan from under patient; then remove equipment from area. .5

DILITATION AND CURETTAGE: Upon arrival in minor surgery room, position patient on the examination table, set-up equipment and assist physician with the procedure. After completion of the procedure, apply perineal pad; then assist patient on stretcher. 10

PATIENT TEACHING:

TEACHING - DIABETIC: Upon arrival at bedside, provide information on the disease process and care related to this process. (Signs and symptoms on insulin lack/overdosage, foot care, rotation of injection sites, exercise program, storage of medication, and maintenance of equipment.) 4

TEACHING - DRESSING CHANGE: Upon arrival at bedside, provide instruction on technique of dressing change, skin care and how to recognize abnormal conditions related to disease/injury. 2

APPENDIX D

Obstetric Patient Classification Tabulation Form

OBSTETRICAL PATIENT CLASSIFICATION TABULATION FORM

TOTAL POINTS	HOURS OF CARE	CATEGORY OF CARE	NO. OF CASES
1 - 39	<1 - 1	1	_____
40 - 79	2 - 3	2	_____
80 - 159	4 - 7	3	_____
160 - 239	8 - 11	4	_____
240 - 499	12 - 24	5	_____

Patient Care Indicator Scores

Nursing Unit _____	Date _____	Hygiene
Rater's Signature _____	Age _____	Nutrition/ Elimination
Bed No. _____	Name of Patient _____	Mobility/ Exercise/Safety
		Psychological/ Patient Teaching
		Vital Signs/ Assessment/ Diagnostic Tests
		Medication
		Gastrointestinal
		Respiratory
		Cardiovascular
		Skin
		Skeletal/ Urological/ Gynecological
		Obstetrical
		Other Therapeutic Activities/ Modalities
		Total PCIS Score
		Category of Care

Obstetrical

[illegible]

APPENDIX E

Methodology for Determining Care Provider Mix for Obstetrics

NURSING CARE HOUR STANDARDS
METHODOLOGY FOR DETERMINING CARE PROVIDER MIX
OBSTETRIC

A. The Percentage Table for Care Provider Mix is a product of Phase II of the Nursing Care Hour Standards Study. During this phase the study team obtained 37,000 on-site measurements at nine medical treatment facilities. These data results were utilized in the development of the personnel percentage table. This percentage table is designed only for use with the Obstetrical Patient Classification Tabulation Form.

B. To compute the number of hours of care by provider groups the following steps must be completed.

1. To determine total hours for each patient care indicator complete the next 3 steps.

a. Using the scores from the Obstetrical Patient Classification Tabulation Form (AHS 091-8 Test), add the PCISs down the patient care indicator column. The total gives the total PCIS for that patient care indicator.

b. Multiply that total PCIS for the column by 3 to obtain total minutes for the patient care indicator column.

c. Divide the total minutes for each patient care indicator column by 60 to find total hours for each patient care indicator.

OBSTETRICAL PATIENT CLASSIFICATION TABULATION FORM	TOTAL POINTS	HOURS OF CARE	CATEGORY OF CARE	NO. OF CASES
	1 - 39	<1 - 1	1	<u>1</u>
	40 - 79	2 - 3	2	<u>3</u>
	80 - 159	4 - 7	3	<u>2</u>
	160 - 239	8 - 11	4	<u>2</u>
	240 - 499	12 - 24	5	<u> </u>

100-497 12-22

			Patient Care Indicator Scores														Total PCIS Score	Category of Care
Nursing Unit			Hygiene	Nutrition/ Elimination	Mobility/ Exercise/Safety	Psychological/ Patient Teaching	Vital Signs/ Assessment/ Diagnostic Tests	Medication	Gastrointestinal	Respiratory	Cardiovascular	Skin	Skeletal/ Urological/ Gynecological	Obstetrical	Other Therapeutic Activities/ Modalities			
Date	0700	20 NOV - 0700 21 NOV																
Nater's Signature	MAT SNAO																	
Bed No.	Age	Name of Patient																
1	23	Patient 1	8.0	7.0	9.5	22.0	25.5	0	2.0	0	14.0	0	8.5	85.0	0	191.5	4	
2	31	Patient 2	4.0	3.0	4.0	7.0	2.0	0	0	0	1.0	0	1.0	2.0	0	24.0	1	
3	27	Patient 3	5.0	0	2.5	15.0	11.0	.5	2.0	1.0	7.5	4.0	7.5	27.0	0	83.0	2	
4	23	Patient 4	13.0	7.0	12.0	22.0	13.5	0	2.0	0	15.0	4.0	7.0	83.0	0	178.5	4	
5	23	Patient 5	11.0	6.0	9.0	12.0	9.5	0	2.0	0	4.0	0	6.0	59.5	0	119.0	3	
6	28	Patient 6	8.0	4.0	9.0	10.0	5.5	0	0	0	2.0	0	0	11.0	0	49.5	2	
7	20	Patient 7	9.0	4.0	9.0	7.5	5.0	0	0	0	2.0	0	2.0	9.0	0	47.5	2	
8	22	Patient 8	19.0	5.0	10.5	17.0	10.0	0	2.0	0	4.0	0	8.0	78.5	0	154.0	3	
		TOTAL POINTS	77.0	36.0	65.5	112.5	82.0	.5	10.0	1.0	49.5	8.0	40.0	355.0		837.0		
		TOTAL MINUTES	231.0	108.0	196.5	337.5	246.0	1.5	30.0	3.0	148.5	24.0	120.0	1065.0		2511.0		
		TOTAL HOURS	3.85	1.80	3.28	5.63	4.10	.03	.50	.05	2.48	.40	2.00	17.75		41.85		

AHS Form 091-8 (Test)
6 October 1980

EXAMPLE: Patient Care Indicator - Hygiene

- Add column down for total points = 77.0 points
- Multiply total points by 3 - $77.0 \times 3 = 231.0$ minutes
- Divide total points by 60 - $231.0 \div 60 = 3.85$ hours

2. To determine hours of care provided by each provider group utilize the total hour score from each patient care indicator located on the Obstetrical Patient Classification Tabulation Form (AHS-091-8 Test) and the Obstetrical Percentage Table for Care Provider Mix which follows:

PERCENTAGE TABLE FOR CARE PROVIDER MIX

OBSTETRIC

PROFESSIONAL TECHNICAL PARAPROFESSIONAL

HYGIENE	15	61	24
NUTRITION/ ELIMINATION	24	55	21
MOBILITY/ EXERCISE/ SAFETY	26	54	20
PSYCHOLOGICAL/ PATIENT TEACHING	60	28	12
VITAL SIGNS/ ASSESSMENT/ DIAGNOSTIC TEST	28	48	24
MEDICATION	89	9	2
GASTROINTESTINAL	40	39	21
RESPIRATORY	37	47	16
CARDIOVASCULAR	74	21	5
SKIN	25	52	23
SKELETAL/ UROLOGICAL/ GYNECOLOGICAL	33	47	20
OBSTETRICAL	65	25	10
OTHER THERAPEUTIC ACTIVITIES/ MODALITIES	42	43	15

Professional =

Registered Professional
Nurses (ANC and DAC 7-13)

Technical =

Licensed Vocational Nurse
(DAC 5-6, 91C10-40 and 91B40)

Paraprofessional =

Nursing Assistants
(DAC 3-4 and 91B10-30)

- Select the total hour score for each patient care indicator.
- Select the personnel percentage score for each patient care indicator.
- Multiply the total hour score for each patient care indicator by the appropriate percentage score.

EXAMPLE: Patient Care Indicator - Hygiene

- Total Hour Score = 3.85
- Personnel percentage score for patient care indicator =
Professional 15%
Technical 61%
Paraprofessional 24%
- Multiply total score for PCIS by the personnel percentage score =
 $15\% \times 3.85 = .58$ hours by professionals
 $61\% \times 3.85 = 2.35$ hours by technicians
 $24\% \times 3.85 = .92$ hours by paraprofessionals

3. To determine total hours of direct care provided by each provider group the following steps must be completed.

a. Add the rows across for the total hours by provider group. This will provide you the total number of hours of direct care by each provider group.

	Hygiene	Nutrition/ Elimination	Mobility/ Exercise/Safety	Psychological/ Patient Teaching	Vital Signs/ Assessment/ Diagnostic Tests	Medication	Gastrointestinal	Respiratory	Cardiovascular	Skin	Skeletal/ Urological/ Gynecological	Obstetrical	Other Therapeutic Activities/ Modalities	
TOTAL HOURS	3.85	1.80	3.29	5.63	4.10	.03	.50	.05	2.48	.40	2.00	17.75	0	
PROFESSIONAL	.58	.43	.85	3.38	1.15	.03	.20	.02	1.84	.10	.66	11.54	0	= 20.78
TECHNICAL	2.35	.99	1.77	1.58	1.97	0	.19	.02	.52	.21	.94	4.44	0	= 14.98
PARAPROFESSIONAL	.92	.38	.66	.67	.98	0	.11	.01	.12	.09	.40	1.77	0	= 6.11

EXAMPLE:

Professional

$$.58 + .43 + .85 + 3.38 + 1.15 + .03 + .20 + .02 + 1.84 + .10 + .66 + 11.54 = 20.78 \text{ TOTAL HOURS BY PROVIDER GROUP}$$

Technical

$$2.35 + .99 + 1.77 + 1.58 + 1.97 + .19 + .02 + .52 + .21 + .94 + 4.44 = 14.98 \text{ TOTAL HOURS BY PROVIDER GROUP}$$

Paraprofessional

$$.92 + .38 + .66 + .67 + .98 + .11 + .01 + .12 + .09 + .40 + 1.77 = 6.11 \text{ TOTAL HOURS BY PROVIDER GROUP}$$

b. Divide the total hours for each provider group by 8 (hours/shift) to obtain number and mix of care providers required for direct care activities.

EXAMPLE:

$$\begin{aligned} 20.78 \div 8 &= 2.60 \text{ Professional mandays of direct care} \\ 14.98 \div 8 &= 1.88 \text{ Technical mandays of direct care} \\ 6.11 \div 8 &= .77 \text{ Paraprofessional mandays of direct care} \end{aligned}$$

4. The investigator recommends that quarterly computations of provider mix will be sufficient.